

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 6390 7/18/67 kk

09112

CERTIFICATE OF DEATH

09111

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baptist Home of Md.		d. STREET ADDRESS 723 Gorsuch Avenue	
3. NAME OF DECEASED (Type or print) First Carolyn Middle Adam Last Adam		4. DATE OF DEATH Month July Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1871
9. AGE (In years last birthday) yrs. 95		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joel O. Adam		14. MOTHER'S MAIDEN NAME Martha D. Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-34-9600	
17. INFORMANT Baptist Home of Md.		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-cerebral Cardiac-Vascular DUE TO 444X (b) Renal Disease & uremia DUE TO old age (c) old age		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to July 9 , 19 67 that (I) (we) last saw the deceased alive on July 9 , 19 67 , and that death occurred at 7:10/67 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Paul Byerly		22b. DATE SIGNED 7/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. Paul Byerly		22d. ADDRESS 5820 York Rd. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25a. REC'D BY REGISTRAR JUL 13 1967	
25b. REGISTRAR'S SIGNATURE James J. Judge		25c. ADDRESS 6500 York Rd. 21212	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
091113					091112				
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk					b. COUNTY Baltimore				
c. LENGTH OF STAY IN 1b 13 Years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2704 Gray Manor Court					d. STREET ADDRESS 2704 Gray Manor Court				
3. NAME OF DECEASED (Type or print) First Joseph Middle K. Last Airey					4. DATE OF DEATH Month July Day 6 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/27		9. AGE (In years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician - Donnelly		10b. KIND OF BUSINESS OR INDUSTRY Advertising Corp.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph F. Airey					14. MOTHER'S MAIDEN NAME Adrianna Jenkins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-8048		17. INFORMANT (Wife) Mrs. Mary J. Airey, 2704 Gray Manor Ct.		Address Dundalk, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, metastatic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Carcinoma of the lungs, primary</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> 19 <i>67</i> to <i>July</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>June 30</i> 19 <i>67</i> , and that death occurred at <i>9:15</i> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Benigno M. Oteyza</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7/6/67	
22c. PHYSICIAN'S NAME (Type) Benigno M. Oteyza					22d. ADDRESS M. D. 1012 Old North Point Rd. Dundalk, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					25a. REC'D BY REGISTRAR DATE JUL 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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• *Journal of Management Education* 25(10):1139-1150

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp</u>		d. STREET ADDRESS <u>3720 McDonough Road</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert S. Arbesman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed Home Improvement</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	9. AGE (In years last birthday) <u>39</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>The Arbesman</u>		14. MOTHER'S MAIDEN NAME <u>Veretly Libbey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive Heart Failure</u> DUE TO (b) <u>SEVERE CORONARY HEART DISEASE</u> DUE TO (c) <u>ATHEROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>RECURRENT PULMONARY EMBOLI</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>67</u> , to <u>7-22</u> , 19 <u>67</u> , that (I) (we) later saw the deceased alive on <u>7-22</u> , 19 <u>67</u> , and that death occurred at <u>6:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>7-22-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Madamba</u>		22d. ADDRESS <u>Balto. Co. Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rosedale, Md.</u>
24. FUNERAL DIRECTOR <u>Del. Quisenberry & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>JUL 26 1967</u>	

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OFFICE OF THE

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SEVERE CORONARY HEART DISEASE

ATHECTIC KIDNEY

RECURRENT PULMONARY EMBOLI

7-22

Dr. A. J. J. J.

JUL 22 1961

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 ver. by phone 7-1 MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
091115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					091114				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1624 Eastern Ave.					d. STREET ADDRESS 1624 Eastern Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM VERNON ARCHER					4. DATE OF DEATH July 8, 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1895		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent			10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. Archer					14. MOTHER'S MAIDEN NAME Blanche Archer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 212 03 1079		17. INFORMANT A. Virginia Luckan 8749 Old Harford Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO HCVI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED 7/8/67	
ACTUAL SIGNATURE Theo C. Patterson			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Theo. C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/ 67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Baltimore, Md.		
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.					25a. REC'D BY REGISTRAR DATE JUL 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

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09115

1. PLACE OF DEATH Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	c. LENGTH OF STAY IN It 2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Villam Maria Rest Home Glenarm, Md.		d. STREET ADDRESS Glenarm Rd., Glenarm, Md.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sister M. Rapheline Backhaus		4. DATE OF DEATH Month 7 Day 12 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years birth day) yrs. 85
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Backhaus		14. MOTHER'S MAIDEN NAME Elizabeth Punte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-54-3905-1	
17. INFORMANT Sr. M. Kathleen Glenarm, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central vascular occlusion DUE TO (b) Pulmonary edema secondary to DUE TO (c) Congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 6, 1966 , to July 6, 1967 , that (I) (we) last saw the deceased alive on July 6, 1967 , and that death occurred at 9:10 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Henry L. McCable		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-13-67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Sisters Cemetery	23d. LOCATION (City or Town) (County) (State) Glen Arm, Maryland
24. FUNERAL DIRECTOR Raymond J. Curran		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1918

San Francisco

June

William Davis (son of Thomas, No.

2142 M. (supplied by Thomas)

White

Living

Thomas Davis

no

2142 M. (supplied by Thomas)

W. H. Davis (son of Thomas, No.

2142 M. (supplied by Thomas)

2142 M. (supplied by Thomas)

2142 M. (supplied by Thomas)

Thomas, (son of)

Thomas, (son of)

2142 M. (supplied by Thomas)

Thomas, (son of)

Thomas, (son of)

1918

San Francisco

1918

San Francisco

1918

1918

1918

1918

1918

1918

CERTIFICATE OF DEATH

09117

09116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Baltimore - Dundalk d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - Dundalk d. STREET ADDRESS 3100 Cornwall Road #21222 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Baby John Boy Bahorich Jr.				4. DATE OF DEATH Month July Day 2 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1967	
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph J. Bahorich				14. MOTHER'S MAIDEN NAME Carol Ann Grayson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Address Dundalk, Md. Joseph J. Bahorich, 3100 Cornwall Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. Hydrocephalus IMMEDIATE CAUSE (a) Hydrocephalus DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 2, 1967 to July 2, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 2, 1967 , and that death occurred at 9:10 P.M. from causes and on the date stated above.							
22a. SIGNATURE Imelda B. Salanio				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 3, 1967	
22c. PHYSICIAN'S NAME (Type) Imelda B. Salanio, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/67		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith Cem.		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. RECEIVED BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE John J. Duda	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

09118		09117	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN lb <u>40 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1700 Rittenhouse Ave.</u>		d. STREET ADDRESS <u>1700 Rittenhouse Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Joseph F. Baker, Sr.</u>		4 DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-3-1926</u> yrs.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>warehouse</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John G. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>014-16-3216</u>	
17. INFORMANT <u>Helen Baker</u>		Address <u>1700 Rittenhouse Ave.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1965, to <u>July 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1967</u> , and that death occurred at <u>7:00 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Bradley Laughsthy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Bradley Laughsthy, M.D.</u>		22d ADDRESS <u>Francis Ave. 147</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>Jul. 25, 67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Ambrose Inc.</u>		25a. REC'D BY REGISTRAR <u>JUL 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

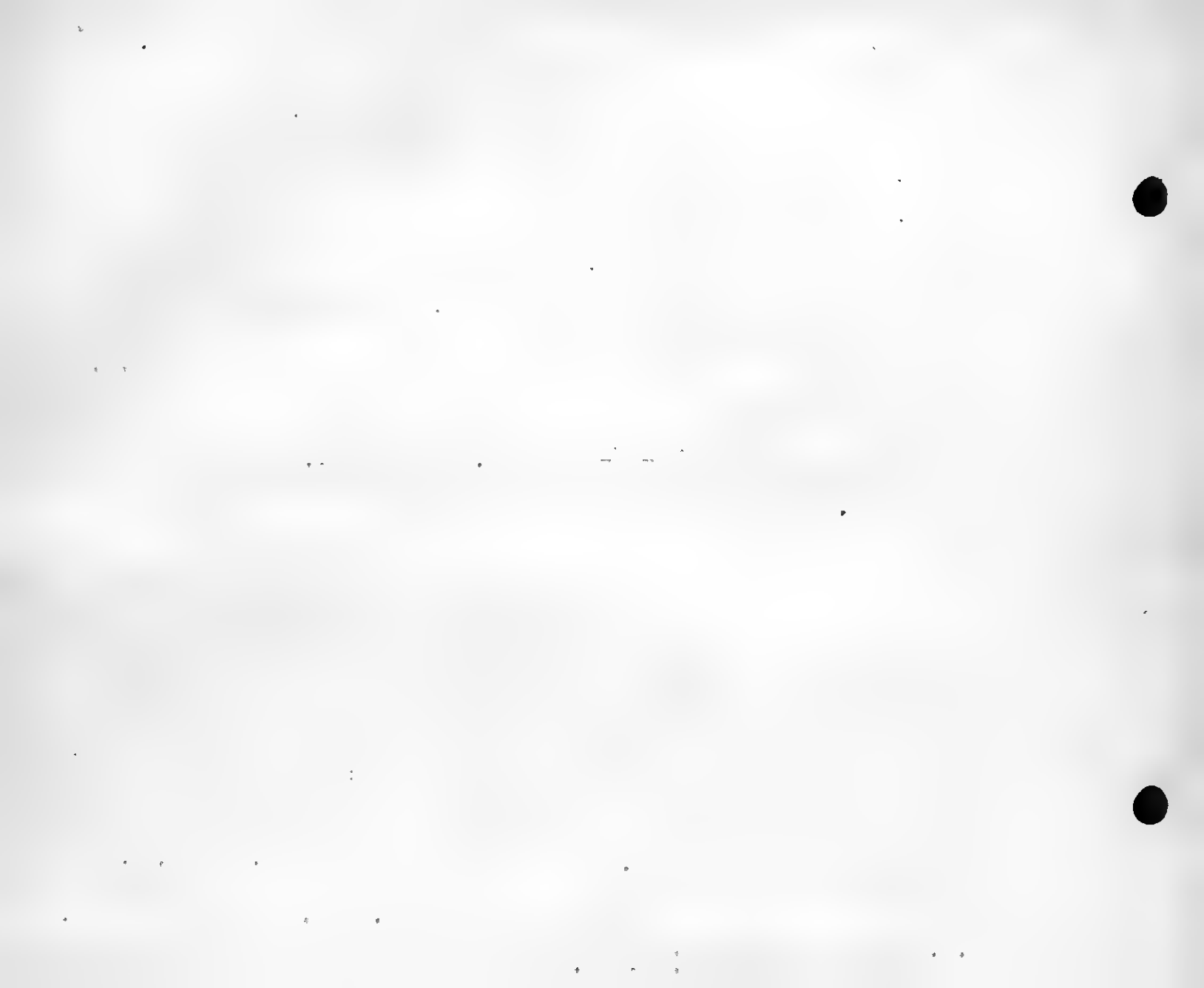
09118

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 700 Woodbourne Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) PRESTON F. BANKERD				4. DATE OF DEATH Month July Day 5 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1908		9. AGE (In years last birthday) yrs 59	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -Salesman		10b. KIND OF BUSINESS OR INDUSTRY GreenSpring Dairy Maryland		11. BIRTHPLACE (County & State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Bankerd				14. MOTHER'S MAIDEN NAME May Prestoh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-05-7907		17. INFORMANT Mrs. Constance A. Bankerd (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastric hemorrhage DUE TO (b) 1875 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour am 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from July 4 , 19 67 , to July 5 , 19 67 , that he (we) last saw the deceased alive on July 5 , 19 67 , and that death occurred at 8:58pm , from causes and on the date stated above.							
22a. SIGNATURE M.S. Cockburn, M.D.				22b. DATE SIGNED July 6, 1967		22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Grds. Timonium, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR JUL 7 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jago	



CERTIFICATE OF DEATH

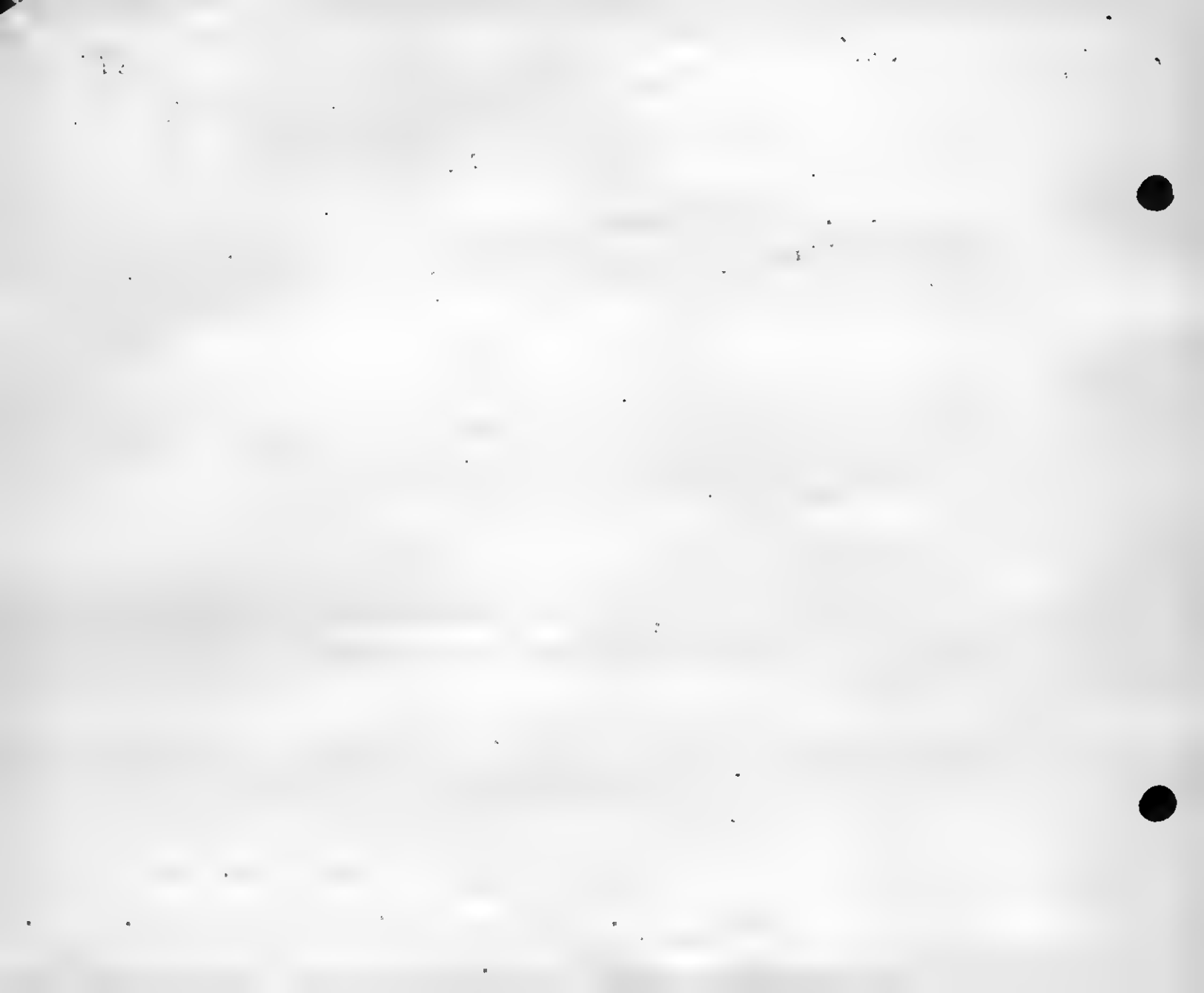
09119

09120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY in 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS Box 171 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE f. SEX F g. COLOR OR RACE Negro h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month 7 Day 14 Year 1967 5. AGE (In years and birthday) 86 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE MATTHEWS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME SARAH REED 16. SOCIAL SECURITY NO Records, Mount Wilson State Hospital	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6.28.67 , 19 to 7.14.67 , that (I) (we) last saw the deceased alive on 7.14.1967 , and that death occurred at 12:03 , from causes on and on the date stated above.			
22a. SIGNATURE W. Newcomer 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland		22b. DATE SIGNED 7.14.1967 22d. ADDRESS Superintendent Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 17 July 67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or town) (County) (State) Aberdeen, (Har.) Md.	
24. FUNERAL DIRECTOR Walter Newcomer Jr.		25a. REC'D BY REGISTRAR Tarring Funeral Home 25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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09121

CERTIFICATE OF DEATH

09123

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN Tb 42 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 1632 E. 30th STREET			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last BARGET				4. DATE OF DEATH Month JULY Day 23 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/94	9. AGE (In years last birthday) yrs 72	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY C. BARGET				14. MOTHER'S MAIDEN NAME ELIZABETH ENGLAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 213 03 77 90		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CARCINOMA OF THE PROSTATE DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Generalized Arteriosclerosis. Chronic Brain Syndrome due to Cerebral Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. NATURE AND CIRCUMSTANCES OF DEATH (Enter nature of injury in Part I or Part II, of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/11 , 19 67 , to 7/23 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/23 , 19 67 , and that death occurred at 5:10 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Pushpendra Senan, M.D.</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/23/67			
22c. PHYSICIAN'S NAME (Type) PUSEPENDRA SENAN, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	23d. LOCATION (City or town) (County) (State) Cockeysville Maryland				
24. FUNERAL DIRECTOR William Cook-Brooks Towson		ADDRESS 1050 York Rd. Towson, Md.	25a. REC'D BY REGISTRAR JUL 27 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jager</i>			

00121

CERTIFICATE OF DEATH

00122

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE MD b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHESAPEAKE MANOR NURS. Home		d. STREET ADDRESS 3010 W. COLD SPRING LANE	
3 NAME OF DECEASED (Type or print) DORA M. BARTON		4. DATE OF DEATH Month JULY Day 21 Year 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT 17, 1887 19 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11 BIRTHPLACE (County & State, or foreign country) HEREFORD CO. MD
13. FATHER'S NAME (unknown) MAYS		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT MRS IRENE B MITCHELL		Address Horseshoe Circle MD	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) carcinoma sigmoid colon. 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/21 , 19 67 , to 7/21 , 19 67 , that (I) (we) last saw the deceased alive on 7/20 19 67 , and that death occurred at 940 PM , from causes and on the date stated above.			
22a. SIGNATURE Francois X. Carmody M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 7/21/67
22c. PHYSICIAN'S NAME (Type) FRANCOIS X CARMODY		22d. ADDRESS 3201 N. CHARLES ST	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/24/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Pikesville & BALTO MD
24. FUNERAL DIRECTOR Loring Byers		25a. REC'D BY REGISTRAR Charles Judge DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Randall Stowers		ADDRESS 8728 Liberty Rd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

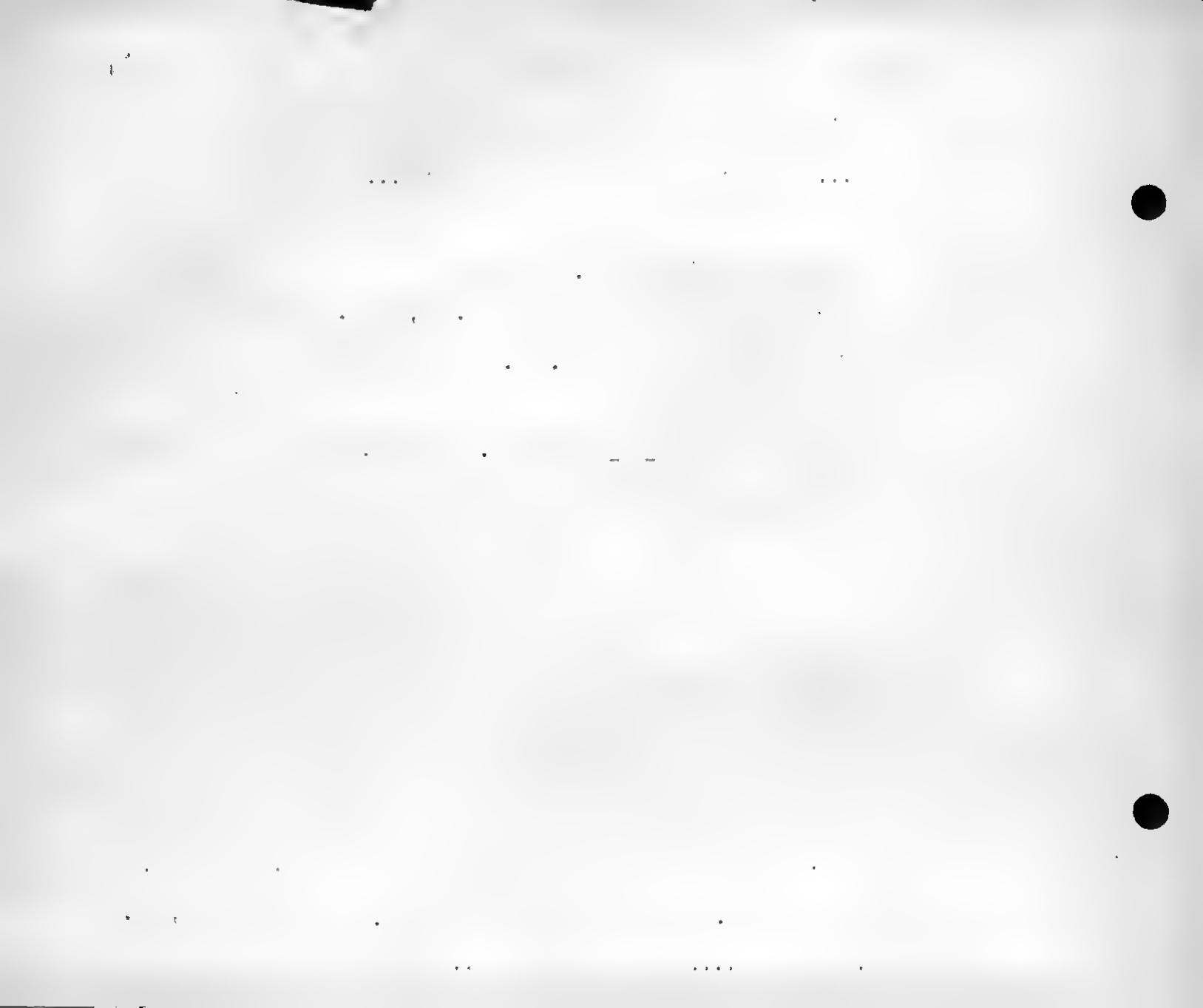
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09123

CERTIFICATE OF DEATH

09122

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural...Baltimore		c. LENGTH OF STAY IN 1b rural...Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3004 Texas Avenue		d. STREET ADDRESS 3004 Texas Avenue	
3 NAME OF DECEASED (Type or print) Melford F. Baynes		4 DATE OF DEATH Month July Day 2 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 15, 1904.
9 AGE (In years last birthday) 62 yrs		10 IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min 2	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machine Operator Western Elec. Co.		10b KIND OF BUSINESS OR INDUSTRY Western Elec. Co.	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Baynes		14. MOTHER'S MAIDEN NAME Lillian ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW 2		16. SOCIAL SECURITY NO 216-03-5724	
17. INFORMANT Mrs. Louise D. Baynes		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis of the posterior + lateral branches DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs + (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 2 yrs +
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12.8 , 19 64 , to 7.2 , 19 67 , that (I) (we) last saw the deceased alive on 12-27-11 19 67 , and that death occurred at 11:52 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph Skloven		22b. DATE SIGNED 7.3.67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Skloven		22d. ADDRESS 7122 Harford Rd., Balto. Co., Md. 21234	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/67.	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc....Baltimore City, Md..14		25a. REC'D BY REGISTRAR DATE JUL 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09124

CERTIFICATE OF DEATH

09123

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 33 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 5 N. ELLIWOOD AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last LEE NMI BECHTOLD		4 DATE OF DEATH Month Day Year JULY 19, 19 67	
5. SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/7/89
9 AGE (In years last b rth day) yrs 78		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	
10b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN BECHTOLD	
14. MOTHER'S MAIDEN NAME MARY BENDORF		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI	
16 SOCIAL SECURITY NO 213 03 14 74		17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. XOUCAR (b) XOUCAR (c) ANEMIA		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR UNKNOWN UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOT BY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (b) (this hospital) attended the deceased from 6/16/67 , 19 67 to 7/19/67 , 19 67 , that (b) (we) last saw the deceased alive on 7/19/67 , 19 67 , and that death occurred at 10:50PM from causes and on the date stated above.			
22a SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 7/20/67	
22c PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/24/67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24 FUNERAL DIRECTOR MORAN FUNERAL HOME		25a. REC'D BY REGISTRAR JUL 24 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c ADDRESS BALTIMORE & POTOMAC STREETS, BALTIMORE, MD.	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09125

09124

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c LENGTH OF STAY IN 1b VISITING	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4211 Chapel Rd. 21128		d STREET ADDRESS Lawenton Ave	
3 NAME OF DECEASED (Type or print) THEODORE ALTON BENDER		4 DATE OF DEATH Month July Day 25 Year 1967	
5 SEX Male	6 COLOR OF RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 22 Oct '04
9 AGE (In years last birthday) 62 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 19 Hours 19 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b KIND OF BUSINESS OR INDUSTRY McCormic Aspiatuse	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bender		14. MOTHER'S MAIDEN NAME Mary Fuka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-09-2670	
17. INFORMANT Mrs Jeanne Nerim		Address 5913 Lock Raven Blvd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I CAUSE WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerosis Cardio Vascular 4201 DUE TO Dissection - Probable Terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary Artery Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN C. Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 7527 Belair Rd	
22. DATE SIGNED 7-25-67			
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 7-28-1967	
23c NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Co. Md.	
24 FUNERAL DIRECTOR Lassalmt Funeral Home		25a REC'D BY REGISTRAR Charles J. J...	
ADDRESS 7411 Belair Road		DATE JUL 28 1967	
		25b REGISTRAR'S SIGNATURE Charles J. J...	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09126

09126

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE Md. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN TB —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4421 Wilkens Ave. 21229		d. STREET ADDRESS 4421 Wilkens Ave. 21229	
3 NAME OF DECEASED (Type or print) Nils I. IVAR Berg		4 DATE OF DEATH 29 July 19 67	
5 SEX Male	6 COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/20/02
9 AGE (In years lost birthday) 64 yrs.		10 IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Mack Truck Co. Sweden	
11. BIRTHPLACE (County & State, or foreign country) Sweden		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - - - Berg		14. MOTHER'S MAIDEN NAME - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-07-1462	
17 INFORMANT Mrs. Dorothea M. Burgoon, 1243 Leeds Terrace		Address 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Pulmonary Embolism Phlebitis - Thigh IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) A.S.C.V.D.			19 WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year 29 July 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 29 July 1967 , to 29 July 1967 , that (I) (was) lost saw the deceased on 29 July 19 67 and that death occurred at — M, from causes on the date stated above.			
22a. SIGNATURE Ralph E. Updike MD		22b. DATE SIGNED 30 July '67	
22c. PHYSICIAN'S NAME (Type) Ralph E. Updike MD		22d. ADDRESS 31 Dogwood Drive 21043	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/1/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR AUG 1 1967 25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1870

1



09127

CERTIFICATE OF DEATH

09126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e. STREET ADDRESS <u>8147 Scots Level RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Berman</u> Last <u>Berman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/90-</u>
9. AGE (In years last b rthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hertza Youngman</u>		14. MOTHER'S MAIDEN NAME <u>Chava ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Mrs. Sylvia Leventhal</u>		Address <u>8147 Scots Level Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insuff. & Cong. Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardio Vas. Disease</u> (c) <u>Ca of Breast</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca of Breast</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>17 Day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>67</u> to <u>7-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>67</u> , and that death occurred at <u>3:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u>		22b. DATE SIGNED <u>July 12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Rolando A. Madamba</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth Moses</u>		23d. LOCATION (City or Town) (County) (State) <u>Pinelawn Babylon, L.I., N. Y.</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

00127

00123

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY General Hospital</u>		d. STREET ADDRESS <u>4857 Reisterstown Road</u>	
3 NAME OF DECEASED (Type or print) <u>Sadie Berman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM COOPER</u>		14 MOTHER'S MAIDEN NAME <u>Sarah Perlman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>101-26-1126</u>	
17 INFORMANT <u>Mr. Abraham S. Berman, 6113 Stuart Avenue</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u> 350X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Parkinson's Disease</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> , 19 <u>67</u> , to <u>7-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>D. Simon, M.D.</u>		22b. DATE SIGNED <u>7-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. SIMON</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>(Anshe Emenah) Aitz Chaim</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09129

CERTIFICATE OF DEATH

09128

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u> <u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>5533 LANHAM WAY</u>		d. STREET ADDRESS <u>5533 LANHAM WAY</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET B. BETZ</u>		4. DATE OF DEATH <u>JULY 13</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1890</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL FAHEY</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CATHERINE KING ABOLLI</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>July</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/12/67</u> 19 <u> </u> , and that death occurred at <u>4:25</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>R. J. Lyden M.D.</u>		22b. DATE SIGNED <u>7/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN M.D.</u>		22d. ADDRESS <u>6402 GOLDEN RING RD. 21237</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>C. O'NEILLY SONS</u>		ADDRESS <u>300 MACE</u>	
25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

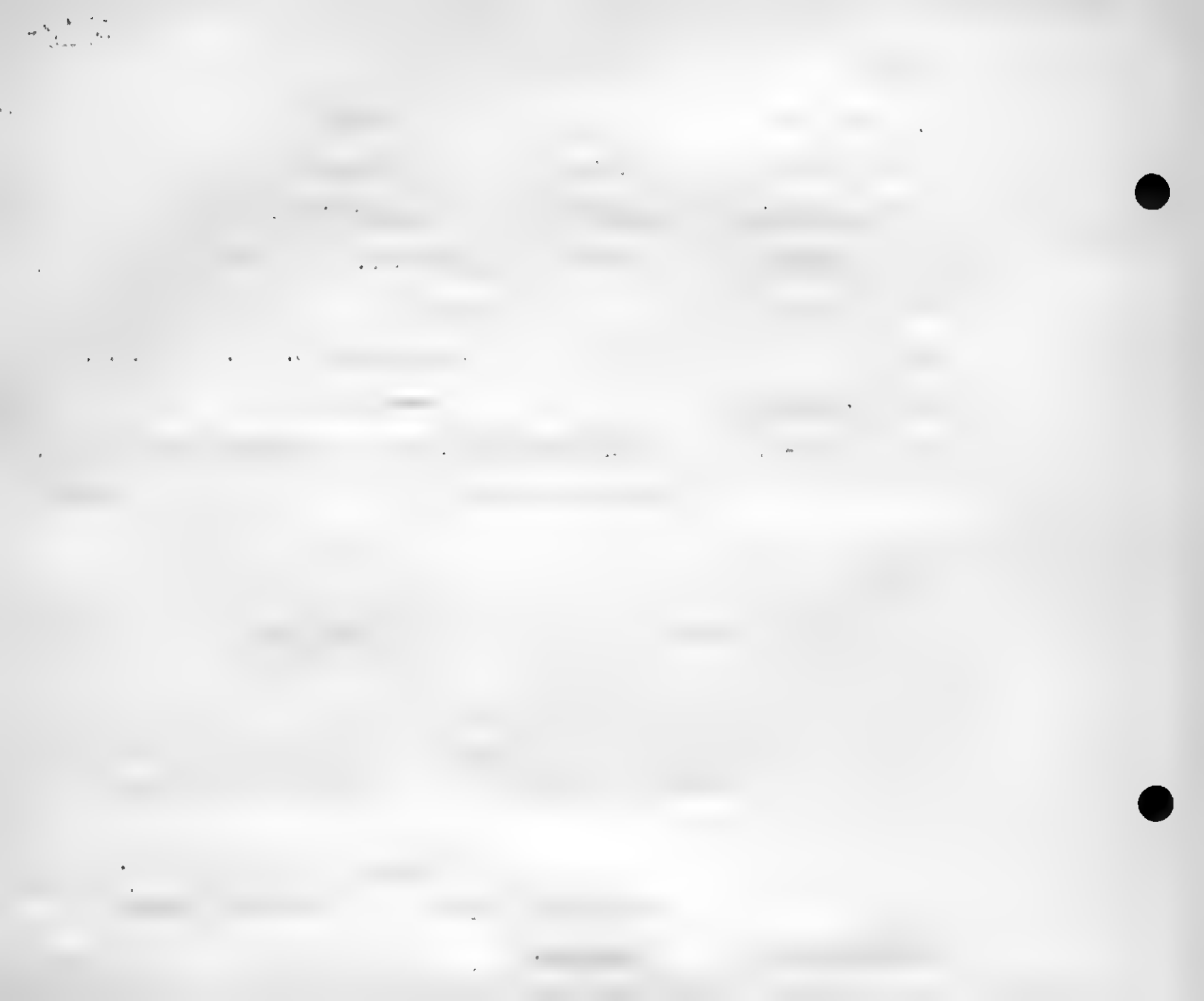
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09130		09129	
1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 48 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 604 Reservoir Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle LINCOLN Last BILLIPS, JR.		4. DATE OF DEATH Month July Day 24 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/24
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		9b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 43
10a. BIRTHPLACE (County & State or foreign country) Chesterfield Co., Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Billips		14 MOTHER'S MAIDEN NAME Mammie Merritt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-11		16 SOCIAL SECURITY NO 223 22 53 33	
17 INFORMANT Clinical Rcds VA Hospital Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY ABSCESSSES, MULTIPLE BRONCHOPNEUMONIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/6/ , 19 67 , to 7/24 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/24/ 19 67 , and that death occurred at 11:50 from causes and on the date stated above.			
22a. SIGNATURE J. O. Pasbert		22b. DATE SIGNED AM	
22c. PHYSICIAN'S NAME (Type) J. O. Pasbert		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/28/67	23c. NAME OF CEMETERY OR CREMATORY FAMILY BURIAL GROUND CHESTERFIELD COUNTY, VIRGINIA	
24. FUNERAL DIRECTOR Wilkerson Funeral Home Petersburg, Va.		25a. REC'D BY REGISTRAR DATE JUL 27 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09138

Reg. Dist. No.

FOR STATE
HEALTH DEPT

09131

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Spam Pt - 19 c. LENGTH OF STAY IN 1b 11-19 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Mt Pleasur Club		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1835 Freedom Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kathleen Antoinette Blair		4. DATE OF DEATH Month Day Year July 9th. 1967	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1956
9. AGE (In years last birthday) 10 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Oscar Ell Blair		14. MOTHER'S MAIDEN NAME Adelia Gregory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Oscar Ell Blair, 1835 Freedom Way		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Slipped from lawn bar into deep water	
20c. TIME OF INJURY Month, Day, Year 20 p.m. 7-9-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches Bay		20f. CITY OR TOWN Spam Pt - Baltimore Md	
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis EXAMINER'S NAME (Type) Melvin B. Davis, M.D. 5800 Morningside Rd.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/10/67 DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Vernon Linn ADDRESS 4611 Park Heights Av. Balto.		24a. REC'D BY REGISTRAR JUL 11 1967 DATE	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09132

CERTIFICATE OF DEATH

09131

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IS <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				d. STREET ADDRESS <u>10318 Malcolm circle</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>P.</u> Last <u>Bond</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-00</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boys Scouts Inc</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Southern Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Francis Parrain Bond</u>				14. MOTHER'S MAIDEN NAME <u>Magill, ESSIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2 8705-0821</u>		17. INFORMANT <u>Patients chart.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>4 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>July 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Richard Frankel</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. Richard Frankel</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkville Md.</u>	
24. FUNERAL DIRECTOR <u>Wm Cock. Brooks Towson</u>				25a. REC'D BY REGISTRAR <u>1030 York Rd Towson, Md</u>		25b. REC'D BY STATE DEPT. OF HEALTH <u>JUL 6 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

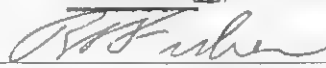
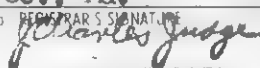
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

09133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09132

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c. LENGTH OF STAY IN 1b Essex (21)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 340 George Avenue				d. STREET ADDRESS 340 George Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS STEVE BORSOS				4. DATE OF DEATH Month Day Year July 16 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1923	9. AGE (In years last birthday) 43 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Borsos				14. MOTHER'S MAIDEN NAME Esther Lukacs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO 218 18 1878		17. INFORMANT Julius Borsos Address 411 Lorraine Ave Balto 21, Md.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO + 221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) July 17, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR Bruzdinski Funeral Home				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE 	
ADDRESS 1407 Eastern Ave. 21							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09134

09133

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural-Parkton</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural-Parkton</i>			
c. LENGTH OF STAY IN 1b <i>60yrs</i>				d. STREET ADDRESS <i>York Rd.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Emory August Borneman</i>				4. DATE OF DEATH <i>July 15 1967</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 15/1892</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tools</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13. FATHER'S NAME <i>Phillip Borneman</i>				14. MOTHER'S MAIDEN NAME <i>Nannie Pearce</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes, WWII-1918-1919</i>				16. SOCIAL SECURITY NO. <i>213-03-0032</i>		17. INFORMANT <i>Thelma F. Borneman, Parkton, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>G.I.S.C.V. disease</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>A. M. F. France</i>				22. DATE SIGNED <i>7/16/67</i>			
EXAMINER'S NAME (Type) <i>A. M. FRANCE</i>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-18-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Clynnmalyria Cem</i>		23d. LOCATION (City, town or county) (State) <i>Monkton, Md.</i>	
24. FUNERAL DIRECTOR <i>Deborah Kortenstien, New Freedom, Pa.</i>				25a. REC'D BY REGISTRAR <i>JUL 19 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

00134

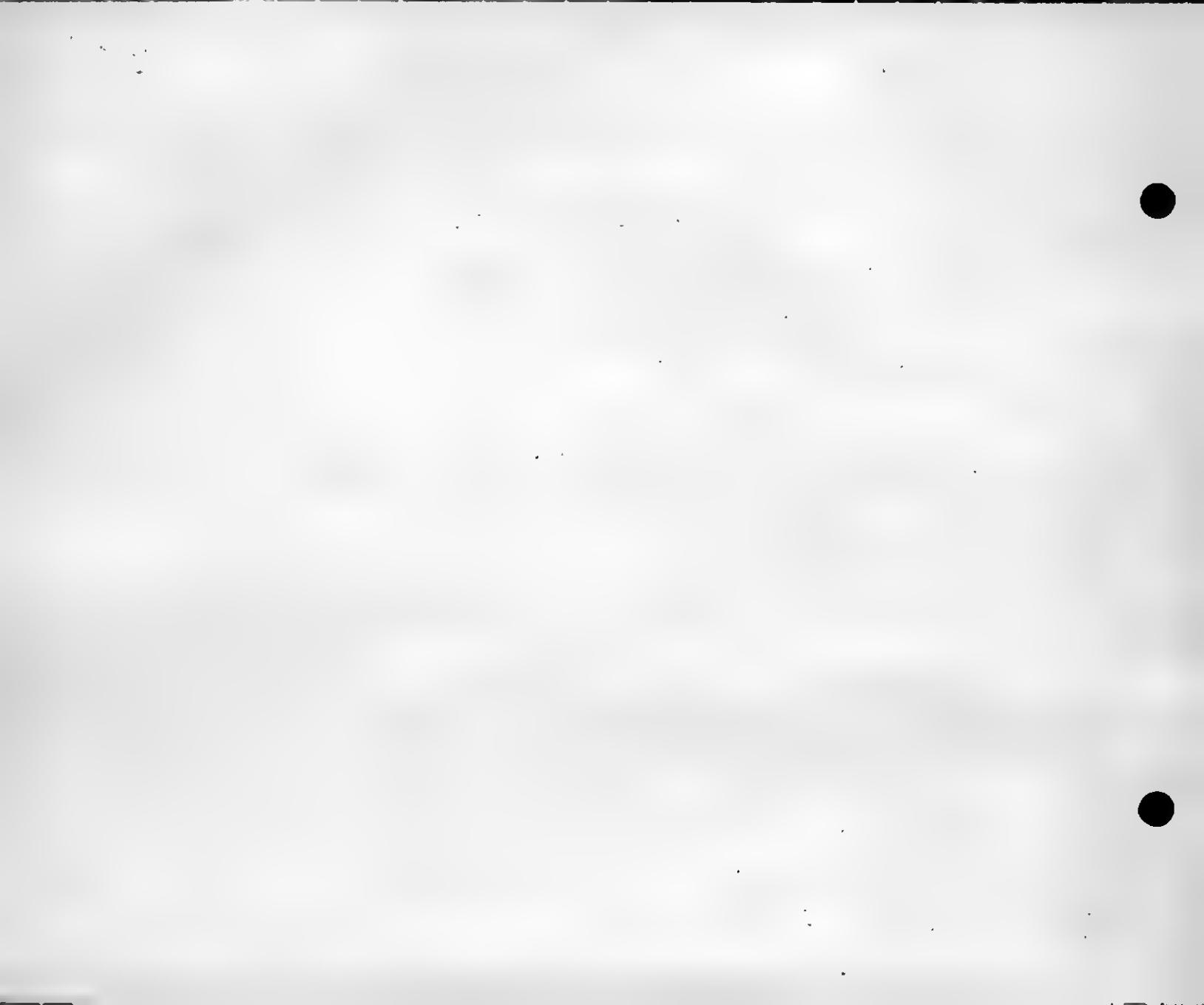
CERTIFICATE OF DEATH

00135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLTOWN</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE CO. GEN. HOSP.</u>		d. STREET ADDRESS <u>8042 LIBERTY RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY CAROLYN BOVETTE</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/26/00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT STORE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CHARLES THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>LOREY (EFFIE)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UN KNOWN</u>		16. SOCIAL SECURITY NO. <u>220-24-3714</u>	17. INFORMANT <u>Edward H Holland</u> Address <u>3725 Coronado Rd, Balt. Md</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Confluent Bronchopneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diffuse pulmonary edema</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Weinfreds M. Iglesias</u>		22b. DATE SIGNED <u>8/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WEINFREDS IGLESIA</u>		22d. ADDRESS <u>Balti. Co. Gen Hosp.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Balt. Md</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u> ADDRESS <u>8728 Liberty Rd Randalltown</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>AUG 3 1967</u>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
09136 Item #8 <u>Edith Linda Brockie</u> 09136														
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6825 Blenheim Road</u>					d. STREET ADDRESS <u>6825 Blenheim Road 12</u>									
3. NAME OF DECEASED (Type or print) <u>Edith Linda Brockie</u>					4. DATE OF DEATH <u>July 24, 1967</u>									
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>10/17/1888</u>					9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - dressmaker</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>					12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>				
13. FATHER'S NAME <u>James</u>					14. MOTHER'S MAIDEN NAME <u>Mary Husband</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO <u>None</u>					17. INFORMANT <u>Mrs. Janet Brockie Box 13 Hazlet, N. J.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coccaroma of ovary</u>														
DUE TO (b) _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____				
20c. TIME OF INJURY Month Day Year <u>July 11 1967</u>										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____										20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that <u>Dr. William F. Renner</u> (this hospital) attended the deceased from <u>July 11, 1967</u> to <u>July 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1967</u> and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.														
22a. SIGNATURE <u>William F. Renner</u> M.D.										22b. DATE SIGNED _____				
22c. PHYSICIAN'S NAME (Type) <u>William F. Renner</u>										22d. ADDRESS <u>5222 St. Paul St, Balt. Md</u>				
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 7/26/1967</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				
23d. LOCATION (City, town or county) <u>Woodlawn, Md.</u>										(State) _____				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickman & Sons</u> ADDRESS <u>Baltimore, Md.</u>										25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>				
25b. REGISTRAR'S SIGNATURE _____										DATE <u>JUL 27 1967</u>				

99137

VR A15 (4)
25M 1/67



00137

09138

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 7 Wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 421 E. 20th Street #21218	
3 NAME OF DECEASED (Type or print) Ellison B. Burch		4. DATE OF DEATH Month July Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-11
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed.		10b. KIND OF BUSINESS OR INDUSTRY Minister	
11. BIRTHPLACE (County & State, or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Burch		14. MOTHER'S MAIDEN NAME Viola Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-202844	
17. INFORMANT Calvin M. Coy - Boston, Mass.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive intra-tracheal hemorrhage DUE TO Fistulous tract between trachea, esophagus and aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the esophagus (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from 5-25- , 1967, to 7-16- , 1967, that (H) (we) last saw the deceased alive on July 16 , 1967, and that death occurred at 8:15 a.m. from causes and on the date stated above.			
22a. SIGNATURE Lawrence Misanik M.D.		22b. DATE SIGNED July 17, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence Misanik M.D.		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/23/67	23c. NAME OF CEMETERY OR CREMATORY Franklin	23d. LOCATION (City or town) (County) (State) Marion, S.C.
24. FUNERAL DIRECTOR Wm. S. Chatham		25. REG. BY REGISTRAR Jul 20 1967	
26. REG. BY REGISTRAR Jul 20 1967		27. REG. BY REGISTRAR Jul 20 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.


VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09139

CERTIFICATE OF DEATH

09138

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3 NAME OF DECEASED (Type or print) Catherine E. Burk		4. DATE OF DEATH July 19, 1967		5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH May 29, 1882		9 AGE (In years lost birthday) yrs 85		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Amrein										14. MOTHER'S MAIDEN NAME Margaret ?											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO. 218 07 2713				17 INFORMANT Hospital Records Address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior septal myocardial infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 4201																		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary thrombo-embolism																		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f (City or town) (County) (State)									
21 I certify that she (this hospital) attended the deceased from July 2, 1967 , to July 19, 1967 that she (we) last saw the deceased alive on July 19, 1967 , and that death occurred at 3:20AM , from causes and on the date stated above.																					
22a SIGNATURE 				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b DATE SIGNED July 19, 1967													
22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.				22d ADDRESS 7620 York Rd., Towson, Md. 21204																	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF July 22, 67				23c NAME OF CEMETERY OR CREMATORY S. Johns Blenheim				23d LOCATION (City or Town) (County) (State) Baltimore Co. Md.									
24. FUNERAL DIRECTOR Will. Cook-Brooks Towson, Towson, Md.										25a REC'D BY REGISTRAR JUL 21 1967				25b REGISTRAR'S SIGNATURE 							

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09140

09138

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1441 Meridene Dr.	
3 NAME OF DECEASED (Type or print) First Middle Last Eldridge Price Burns		4 DATE OF DEATH Month Day Year July 24, 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-16-1890
9 AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Optician	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 197-01-6047	
17 INFORMANT Address Mrs Hazel Burns 1441 Meridene Rd. Balto.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis generalized severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, microcytic and hypochromic. Secondary to G.I. Bleeding			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from July 24, 1967 to July 24, 1967 , that I (we) lost saw the deceased alive on July 24, 1967 , and that death occurred at 2 P.M. from causes and on the date stated above.			
22a SIGNATURE Manuel S. Cockburn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF July 27, 1967	23c NAME OF CEMETERY OR CREMATORY Loudon Park	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Witzke 4101 Edmondson Ave Balto. Md.		25a. REC'D BY REGISTRAR DATE JUL 27 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Items 1, 14 Film</div> <div>408 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>09141 1/10/69 jmj</div> <div>CERTIFICATE OF DEATH</div> <div>09140</div>																	
1. PLACE OF DEATH a. COUNTY <u>BALT. more</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN b. <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bent Nursing Home Baltimore Maryland</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2732 Baker Street</u> d. STREET ADDRESS _____											
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Joseph</u> Last <u>BUTLER</u>						4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1967</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph Butler</u>						14. MOTHER'S MAIDEN NAME <u>Alice Butler</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____						16. SOCIAL SECURITY NO. _____						17. INFORMANT <u>Mrs. Elva Caldwell</u> Address <u>2732 Baker St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertension</u> (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____		(State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>July 1967</u> , that (I) (we) last saw the deceased alive on <u>7/2/67</u> and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Philip Bernstein</u> M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/6/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>PHILIP BERNSTEIN</u>						22d. ADDRESS _____											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>				23d. LOCATION (City, town or county) <u>Balt.</u>		(State) <u>Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert & Cyeth</u>						ADDRESS <u>761 Lenoir</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cat bones, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

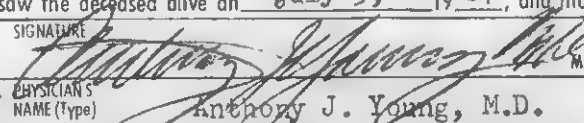

MARYLAND STATE DEPARTMENT OF HEALTH

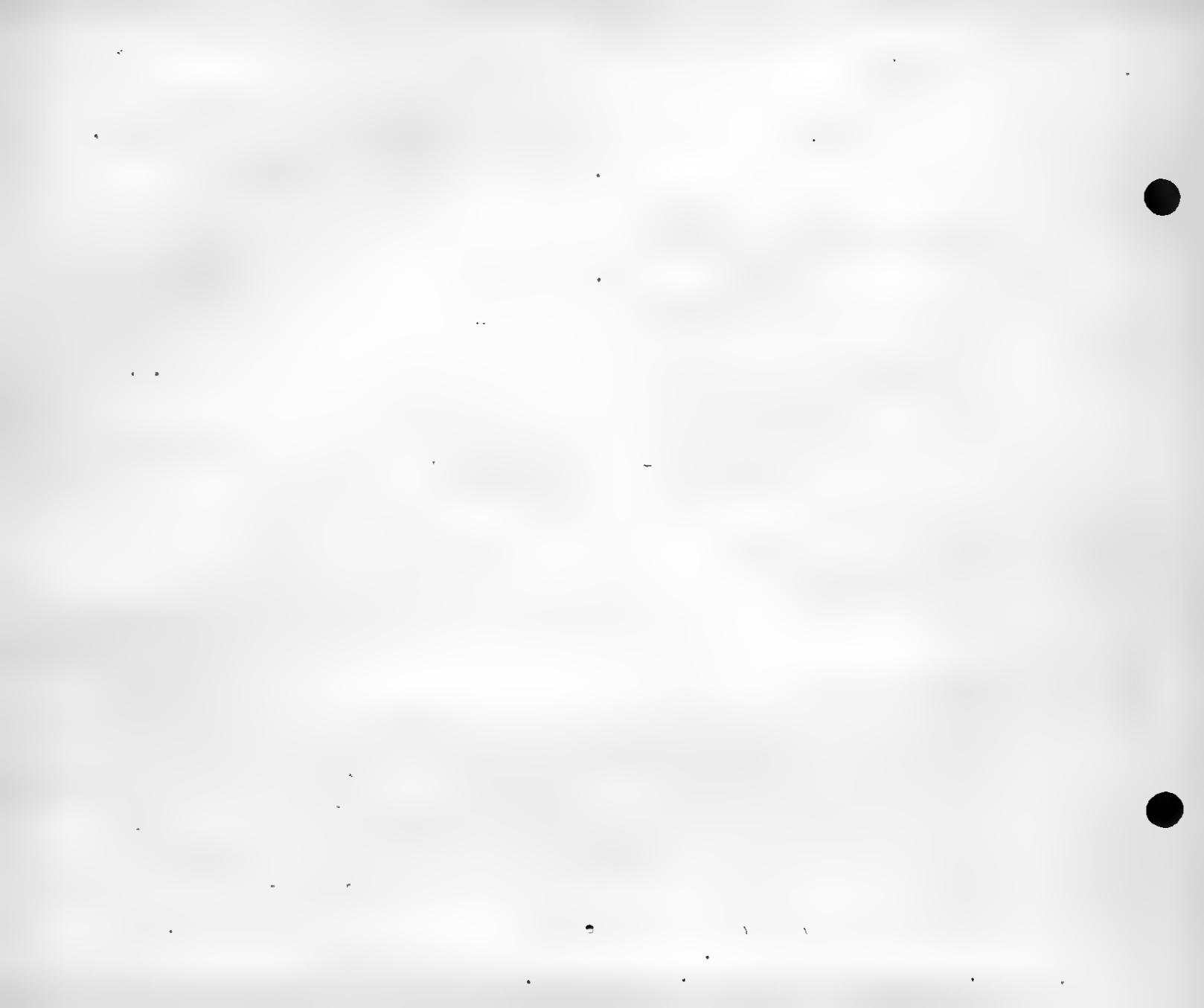
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09142

CERTIFICATE OF DEATH

09141

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c LENGTH OF STAY in 1b 1yr. 26dys		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Maryland 21204		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d STREET ADDRESS 114 Edgewood Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Effie Middle H. Last Callender				4 DATE OF DEATH Month July Day 5 Year 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-14-78		9 AGE (In years last birthday) yrs 89	IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Hallick				14 MOTHER'S MAIDEN NAME Emma East			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 383-09-6910		17. INFORMANT Address Records: Spring Grove State Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 6, 1967 to July 5, 1967 , that (X) (we) last saw the deceased alive on July 5, 1967 , and that death occurred at 1:05 M, from causes and on the date stated above							
22a SIGNATURE  M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 7-5-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				22d ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE THEREOF 7/6/67		23c NAME OF CEMETERY OR CREMATORY Greenmount		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR 1050 York Rd.				ADDRESS Wm. Cook-Brooks Towson Inc. Towson, Md. 21204		25a. REC'D BY REGISTRAR JUL 10 1967	
						25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09143

09142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore				c. LENGTH OF STAY IN 1b 41 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brightside Road				e. STREET ADDRESS Brightside Road			
3. NAME OF DECEASED (Type or print) Margaret Fitts Carey				4. DATE OF DEATH July 10 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1898		9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edwin A. Fitts				14. MOTHER'S MAIDEN NAME Louise MacDonald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 215-48-8779		17. INFORMANT G. Cheston Carey		Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1965 to July 10, 1967 , that (I) had last saw the deceased alive on July 8, 1967 , and that death occurred at 12:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE L. Myrton Gaines				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) Dr. L. Myrton Gaines				22d. ADDRESS 7800 York Rd., Towson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Balto., Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				25a. REC'D BY REGISTRAR 4905 York Rd., Balto., Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8036 Old Chula Rd</u>		d. STREET ADDRESS <u>8036 Old Chula Rd</u>							
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>A.</u> Last <u>Caerman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Nov. 14 1911</u>		9. AGE (In years last birthday) <u>55</u> yrs.		10. FUNDERS 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Wm Ullrich</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Burger</u>		15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Husband</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma ovary</u> DUE TO (c) <u>Papillary adenocarcinoma</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/8, 1965</u> , to <u>7/4, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/3, 1967</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>S A Alessi</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/6/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>S A. Alessi M.D.</u>		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City, town or county) (State) <u>Balto</u>			
24. FUNERAL DIRECTOR <u>Pattelemann</u>		ADDRESS <u>6067 Harbor Ex</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. J...</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09145

CERTIFICATE OF DEATH

09145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 7 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Home</u>		d. STREET ADDRESS <u>5311 Jeyer Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Margaret Alma Chambers</u>		4 DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-28-1886</u>
9 AGE (In years lost birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md.</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13 FATHER'S NAME <u>Thomas M. Henry</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Cowings</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO <u>220-20-9470</u>		17 INFORMANT Address <u>Md. Masonic Home Records</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Cerebral Vascular</u> DUE TO <u>Remontage</u> (b) <u>Arterial Hypertension</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 1965, to <u>July 28</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 28</u> , 1967, and that death occurred at <u>4:25</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>JAMES H. HAMED, M.D.</u>		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED, M.D.</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson T050 York Rd. 21204</u>		25a REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

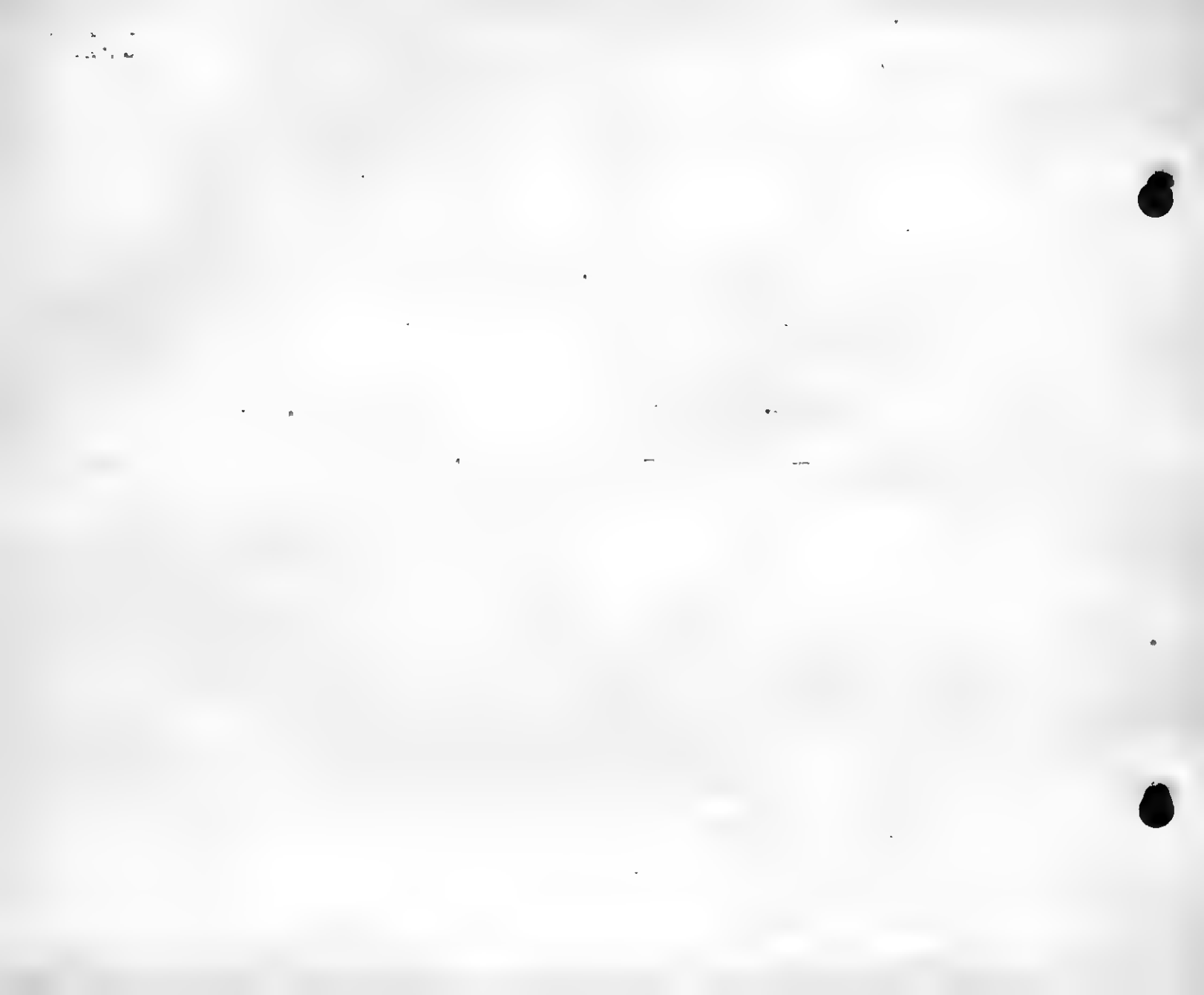
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09146		09146	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #21236	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 4502 Fullerton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adrian M. Chandler		4. DATE OF DEATH Month July Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1908 9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Ackerman & Baynes	11. BIRTHPLACE (County & State, or foreign country) Onancock, Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wilbert M. Chandler	
14. MOTHER'S MAIDEN NAME Minnie C. White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 228-01-8843		17. INFORMANT Address Sue B. Chandler 4502 Fullerton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardiovascular disease. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 3 , 1967, to July 4 , 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 4 1967, and that death occurred at 11:45 PM from causes on and on the date stated above.			
22a. SIGNATURE M. S. Cockburn, M.D.		22b. DATE SIGNED July 5, 1967	
22c. PHYSICIAN'S NAME (Type) M. S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 8 1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Taylor Ave Balto Md
24. FUNERAL DIRECTOR The Dippel Brothers Inc 7110 Belair Road		25a. REC'D BY REGISTRAR DATE JUL 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #7	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSP		d. STREET ADDRESS 910 MASEFIELD ROAD	
3 NAME OF DECEASED (Type or print) First ANNA Middle CHIARAMONTE Last CHIARAMONTE		4. DATE OF DEATH Month July Day 15 Year 1967	
5. SEX F	6 COLOR OR RACE CAUS.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-27-88
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11 BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? ITALIAN	
13. FATHER'S NAME SAVERIO PARINELLO		14 MOTHER'S MAIDEN NAME BRIDGETT PANICOLA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-54-2982	
17 INFORMANT Mrs. Beatrice MANELLI		Address 910 Masefield Rd., Balt.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420' Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) NONE.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 4/24 , 19 67 , to 7/15 , 19 67 , that (I) (we) last saw the deceased alive on 7/15 , 19 67 , and that death occurred at 7 A.M. from causes and on the date stated above			
22a. SIGNATURE Vicente M. Russo MD		22b. DATE SIGNED 7-15-67	
22c. PHYSICIAN'S NAME (Type) VICENTE M. RUSSO		22d. ADDRESS Spring Grove State Hosp.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7-18-1967	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Frank DeLaHoe		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 322 S. High St		DATE JUL 17 1967	

MEDICAL CERTIFICATION

09148

09148

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission): a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>2808 Ulman Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Bessie P. Cohen</u>		4. DATE OF DEATH <u>7 13 19 67</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Partner, Mendel T.</u>		14. MOTHER'S MAIDEN NAME <u>Fruma ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Hospital chart</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gen. ASCVD with Congestive</u> DUE TO <u>Cardiac Failure</u> (b) <u>Diabetes Mellitus with Diabetes</u> DUE TO <u>Diabetes Mellitus with Diabetes</u> (c) <u>Diabetes Mellitus with Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-27</u> , 19 <u>67</u> to <u>7-13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>67</u> , and that death occurred at <u>12:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. Simon</u>		22b. DATE SIGNED <u>7-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. Simon</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Zion</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bns. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

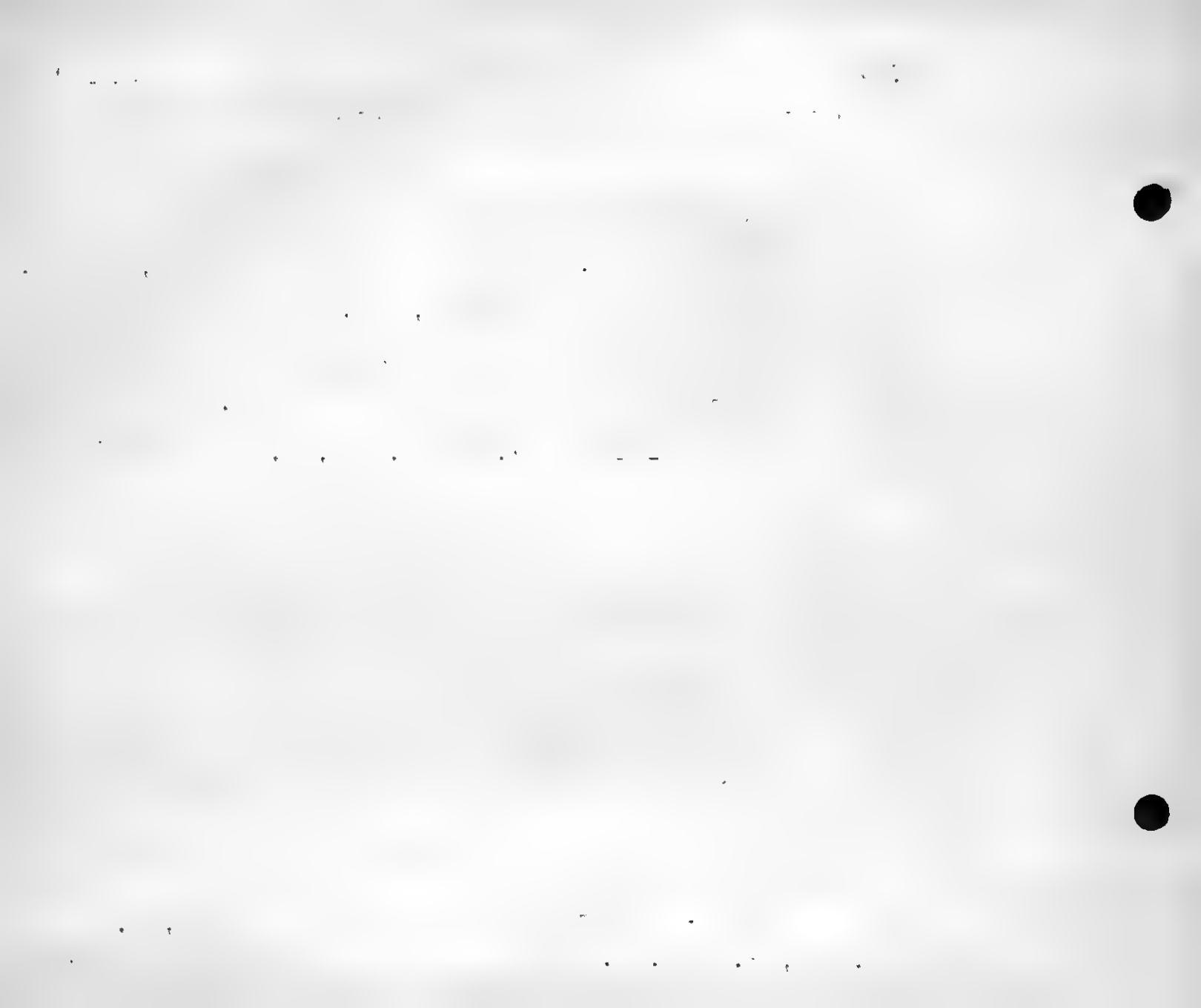
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN lb Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8208 Harford Road		d. STREET ADDRESS 8208 Harford Road	
3 NAME OF DECEASED (Type or print) MARGARET V. COLE		4 DATE OF DEATH Month July Day 27 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1893.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 74 IF UNDER 1 YEAR Months Days Hours Min
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Whelan		14. MOTHER'S MAIDEN NAME Mary J. Manuel	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 214-14-7506	
17. INFORMANT Mr. Elmer L. Cole, Sr.		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Carcinoma of Rectum. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 27 July, 1967 , to 8:30 27 July 1967 , that (I) (we) lost saw the deceased alive on 27 July 1967 , and that death occurred at 8:30 M, from cause and on the date stated above.			
22a. SIGNATURE John C. Hyle		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type) JOHN C. Hyle		22d. ADDRESS 7527 Belair Rd Baltimore Md	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b DATE THEREOF 7/31/67.	23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a REC'D BY REGISTRAR DATE JUL 28 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

09149

09149



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1

20150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09159

1. PLACE OF DEATH a. COUNTY CHARLES BOLLARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville // Baltimore 21227	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CATON RIDGE NURSING HOME		d. STREET ADDRESS 1237 Vogt Ave. 327 Harlem Lane // 28	
3. NAME OF DECEASED (Type or print) CHARLES C. B. Collars		4. DATE OF DEATH 7 - 19 - 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1875
9. AGE (in years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Augustus Collars		14. MOTHER'S MAIDEN NAME Laura Virginia ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-16-0721	
17. INFORMANT Miss H. L. Parke		Address 503 Title Building	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure DUE TO (b) ASCVD DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 17-7-1967 to 7-14-1967 , that (I) (we) last saw the deceased alive on 7-19-1967 , and that death occurred at 7 P M , from the causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Caverio		22b. DATE SIGNED 7-19-67	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS 8629 Liberty Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/22/1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR M. J. Tubman		25a. REC'D BY REGISTRAR JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

09151

09151

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN Tb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1624 E. Clement Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLIE ROBERT CONGO				4. DATE OF DEATH Month Day Year July 8 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1923 43 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driller		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (County & State, or foreign country) Glamorgan, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tony Congo				14. MOTHER'S MAIDEN NAME Euney Tomko			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 223 26 38 39		17. INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE GALL BLADDER, PROBABLE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PANCREATIC NECROSIS, RECENT. PORTAL CIRRHOSIS, LIVER							INTERVAL BETWEEN ONSET AND DEATH RECENT
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/7/67 , 19 67 , to 7/8/67 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/8/67 , 19 67 , and that death occurred at 11:45 AM , from causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VAN FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-12-67		23c. NAME OF CEMETERY OR CREMATORY Smith Cemetery		23d. LOCATION (City or Town) (County) (State) Wise Virginia	
24. FUNERAL DIRECTOR John R. Slack				25a. REC'D BY REGISTRAR Higinbotham Slack Funeral Home DATE JUL 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

09152

09152

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> <u>131</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>127 Warwick Dr</u>		d. STREET ADDRESS <u>127 Warwick Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Fred</u> First Middle Last <u>E. Conrad</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 5, 1913</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mutual Clerk</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Fred Conrad</u>		14. MOTHER'S MAIDEN NAME <u>May Heil</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>218-07-4210</u>	
17 INFORMANT <u>Mrs. Catherine Conrad same as 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>12/11, 1967</u> to <u>7/2, 1967</u> , that (I) (we) last saw the deceased alive on <u>7-2-1967</u> , and that death occurred at <u>7-2-1967</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Charles F. Connelley</u> M.D. 22c. PHYSICIAN'S NAME (Type)		22b. ADDRESS ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> <u>7/5/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>July 6, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Road</u> <u>Towson, Maryland 21204</u>		25a REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one copy, within 72 hours after death.

SHIPPED TO: BECK & DOUGHERTY FUNERAL HOME, NEWPORTVILLE RD., LEVITTOWN, PA.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09153

CERTIFICATE OF DEATH

09153

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 170 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 6825 ROBERTS AVENUE	
3. NAME OF DECEASED (Type or print) MARIE C. CONROY		4. DATE OF DEATH Month JULY Day 7 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 24, 1920
9. AGE (In years last birthday) yrs 47		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYMENT INTERVIEWER		10b. KIND OF BUSINESS OR INDUSTRY EMPLOYMENT SECURITY	
11. BIRTHPLACE (County & State, or foreign country) MAUCH CHUNK, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLETUS EUGENE CONROY		14. MOTHER'S MAIDEN NAME CATHERINE FREDERICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 201 07 30 13	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 491x CYSTADENOCARCINOMA RIGHT OVARY WITH WIDESPREAD METASTASIS HYDRONEPHROSIS, BILATERAL		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) /		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 1/18/67 , 19__, to 7/7/67 , 19__, that (X) (we) last saw the deceased alive on 7/7/67 , 19__, and that death occurred at 8:50AM from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 7/7/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7/8/67	
23c. NAME OF CEMETERY OR CREMATORY ST. PAUL & PETER CEMETERY		23d. LOCATION (City or Town) (County) (State) LEHIGHTON, PENNSYLVANIA	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. RECEIVED BY REGISTRAR JUL 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE BALTIMORE, MD.	

09154

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 2215 Ashton St. 21223	
3. NAME OF DECEASED (Type or print) Mina First Middle Last		4. DATE OF DEATH July 3 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/93
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Rider		14. MOTHER'S MAIDEN NAME Katherine - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 214-12-8112	
17. INFORMANT Mr. Alvin L. Leroy		Address One Oak Place 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Chorio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 90 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1967 to July 3, 1967 , that (I) (we) last saw the deceased alive on July 2, 1967 , and that death occurred at 10:00 M, from causes and on the date stated above.			
22a. SIGNATURE Wetherbee Fort		22b. DATE SIGNED July 4, 1967	
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort		22d. ADDRESS 60 Ashton Ave - Catonsville 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/5/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REG-STRAR JUL 6 1967 DATE	

09155

09155

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 16 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 2209 Rockwell Avenue	
3. NAME OF DECEASED (Type or print) J. WILSON CORWIN		4. DATE OF DEATH Month JULY Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1900
9. AGE (in years last birthday) 67		10. IF UNDER 1 YEAR Months 11 Days 14 Hours 11 Mins. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Administrator		10b. KIND OF BUSINESS OR INDUSTRY Hospitals	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel J. Corwin		14. MOTHER'S MAIDEN NAME Florence Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-22-38-53	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 451X IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) ACUTE HEMORRHAGIC PANCREATITIS, POST-OPERATIVE DUE TO (c) ANEURYSM OF ABDOMINAL AORTA		INTERVAL BETWEEN ONSET AND DEATH 30 HOURS 1 1/2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 451X (this hospital) attended the deceased from June 28, 1967 to July 14, 1967 , that xxx (we) last saw the deceased alive on July 14, 1967 , and that death occurred at 10:15 PM from causes and on the date stated above			
22a. SIGNATURE Madhav D. Barhanpurkar, M.D.		22b. DATE SIGNED 7/15/67	
22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-19-1967	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR MacNabb Funeral Home		25a. REC'D BY REGISTRAR Frederick Rd. & Wade Ave Baltimore, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 20 1967	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09156

CERTIFICATE OF DEATH

09156

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EATONSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>				d. STREET ADDRESS <u>514 HILTON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JAMES H. COSTIN</u>				4 DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1967</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/4/95</u>		9 AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. H. R. R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JAMES HENRY COSTIN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH TURNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>205 115443</u>		17. INFORMANT <u>MRS. JAMES MIDDLETON</u> Address <u> </u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate Gland</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 Mar</u> , 19 <u>67</u> to <u>12 July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 July</u> 19 <u>67</u> , and that death occurred at <u>3:30 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. K. Sullivan, Jr.</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12 July 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. K. Sullivan, Jr.</u>				22d. ADDRESS <u> </u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>		23d. LOCATION (City or Town) (County) (State) <u>CENTERTVILLE, MD</u>	
24 FUNERAL DIRECTOR <u>E.S. MACNABB</u>				25a REC'D BY REGISTRAR <u>301 FREDERICK RD.</u> <u>21228</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

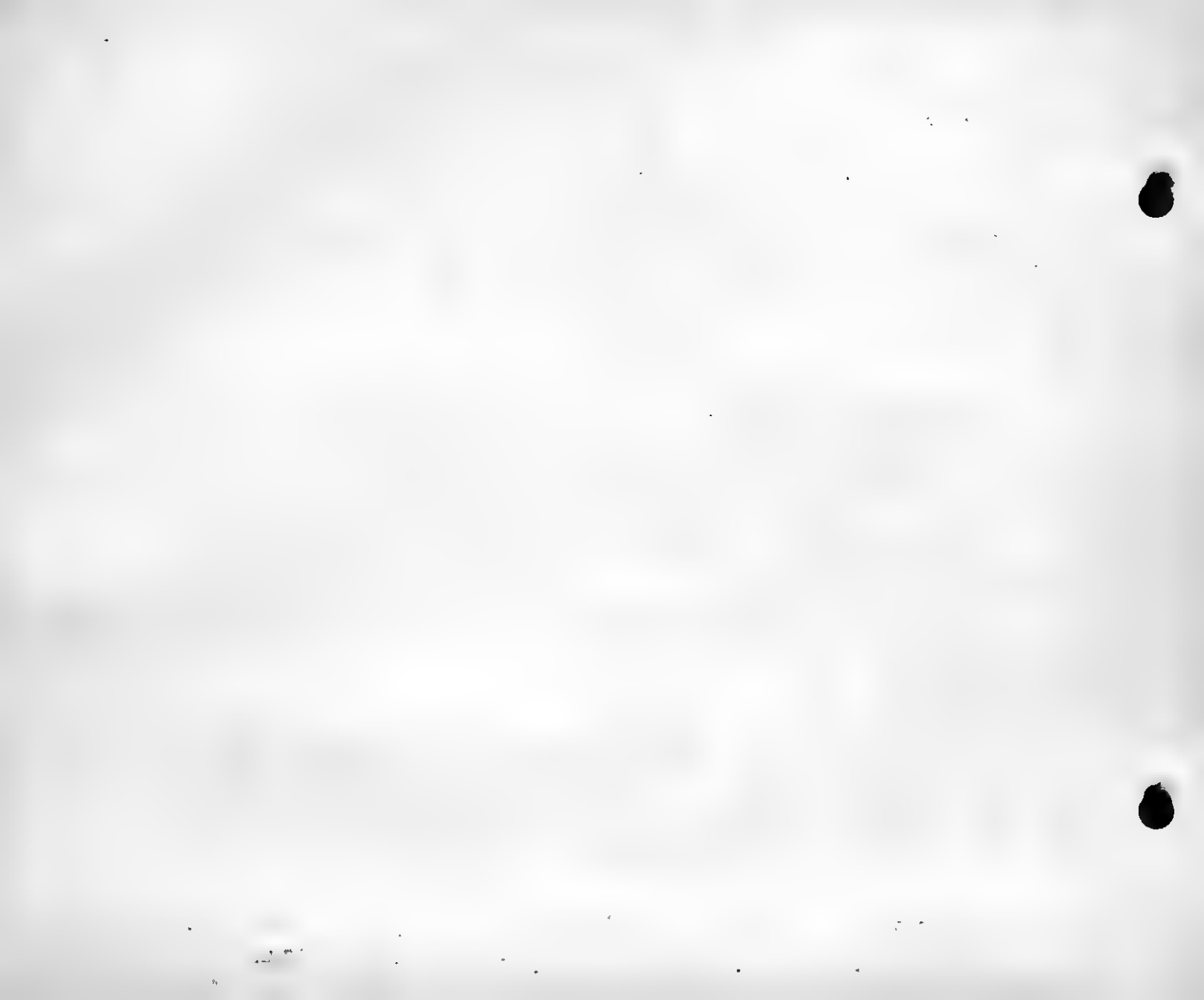
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 See birth cert. and

CERTIFICATE OF DEATH

09157		09157	
1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b less than 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS 5217 Frankford Ave. 21206 6701 N. Charles Street	
3. NAME OF DECEASED (Type or print) Baby		4. DATE OF DEATH Month 7 Day 12 Year 19 67	
5 SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/12/67
9 AGE (In years lost birthday) yrs 0		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 11 Min 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edward James Crafts		14. MOTHER'S MAIDEN NAME Karin Christa Probst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. -----	
17. INFORMANT Maternal History		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Neonatal apnea and atelectasis DUE TO (b) Immaturity (800 gms.) DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 67 , to 7/12 , 19 67 , that (I) (we) last saw the deceased alive on 7/12 19 67 , and that death occurred at 6:45 M. from causes and on the date stated above.			
22a. SIGNATURE John E. Adams 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22b. DATE SIGNED 7/13/67 M.D. ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/14/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		25a. REC'D BY REGISTRAR JUL 14 1967	25b. REGISTRAR'S SIGNATURE James J. Jones



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Parkton c LENGTH OF STAY IN TOWN minutes d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harris Mill Road		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton d STREET ADDRESS York Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES SAMUEL CUMMINGS		4 DATE OF DEATH Month July Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Sept. 21, 1935
9. AGE (in years lost birthday) yrs 31		10. BIRTHPLACE (State or foreign country) White Hall, Md.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) White Hall, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Walter J. Cummings		14 MOTHER'S M maiden name Irene McCarthy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes - 1956-1958		16 SOCIAL SECURITY NO 216-30-0213	
17 INFORMANT Walter Cummings		Address Parkton, Md.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of Stomach Contents complicating Cerebral Injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subj. driving - car ran off road and flipped over			
20a EXTERNAL CAUSE WAS PRIMARY CAUSE CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) car ran off road and flipped over	
20c TIME OF INJURY Month, Day, Year 11:00 pm July 19, '67		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f (City or town) (County) (State) Baltimore, MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 7/20/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county) New Freedom, Pa.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF July 23, 1967	
23c NAME OF CEMETERY OR CREMATORY Middletown Cemetery		23d LOCATION (City or town) (County) (State) Freeland, Md.	
24 FUNERAL DIRECTOR Isaac Kortenslein		25a REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 24 1967	



CERTIFICATE OF DEATH

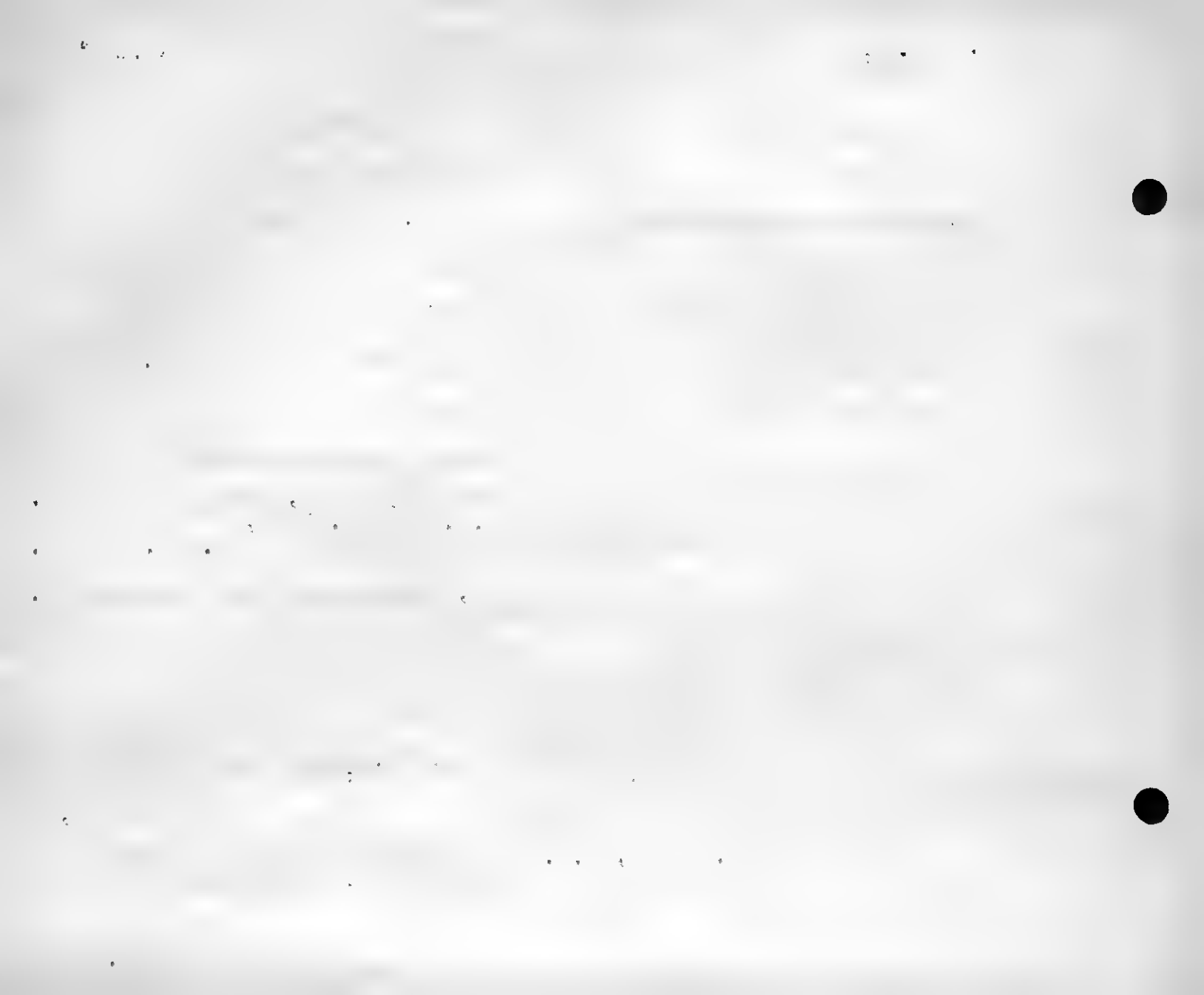
09159

09159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
c. LENGTH OF STAY IN 1b 26yr11mth22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 705 E. 22nd Street	
3. NAME OF DECEASED (Type or print) First James Middle Curtain Last Curtain		4. DATE OF DEATH Month July Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-03
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drug store clerk	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Curtain		14. MOTHER'S MAIDEN NAME Rose Stitely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute, death, DUE TO with previous M.I. in Feb. 1955, (b) Arteriosclerotic Cardiovascular Ht. dis. DUE TO Arteriosclerosis, Generalized, senile (c) 10 min. 12 yrs. 14 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 18, 1940 , to July 19, 1967 that (we) last saw the deceased alive on July 10, 1967 , and that death occurred at 2:00 PM from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/11/67		23b. DATE THEREOF 9/11/67	
23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Maryland		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland 21228	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
ADDRESS		DATE JUL 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



09169

CERTIFICATE OF DEATH

09160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1yr10mth25dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1210 Glyndon Avenue # IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine Delivuk First Middle Last 4. DATE OF DEATH July 18 1967 Month Day Year				5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Yugoslavia 12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Michael Kovachovich 14. MOTHER'S MAIDEN NAME Martha Stanich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO 219-54-3090 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis, advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that she (this hospital) attended the deceased from Aug. 17, 1965 to July 18, 1967 , that she (we) lost saw the deceased alive on July 18, 1967 , and that death occurred of 10:30 M, from causes on and on the date stated above. 22a. SIGNATURE Anthony J. Young 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				22b. DATE SIGNED 7-19-67 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 7-22/1967 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery 23d. LOCATION (City or Town) (County) (State) Uniontown, Pennsylvania				24. FUNERAL DIRECTOR Easton Funeral Home Catonsville 25a. REC'D BY REGISTRAR JUL 25 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09161

CERTIFICATE OF DEATH

09161

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridenwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Nursing Home</u>		d. STREET ADDRESS <u>Willow Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Gona</u> Middle <u>Virginia</u> Last <u>Dempsey</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 24, 1874</u>
9. AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Family information</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1965</u> to <u>July 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1967</u> , and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>7/24/67</u>
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE THEREOF <u>July 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jessop's Methodist Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>
24. FUNERAL DIRECTOR <u>Jo'n Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09162

09162

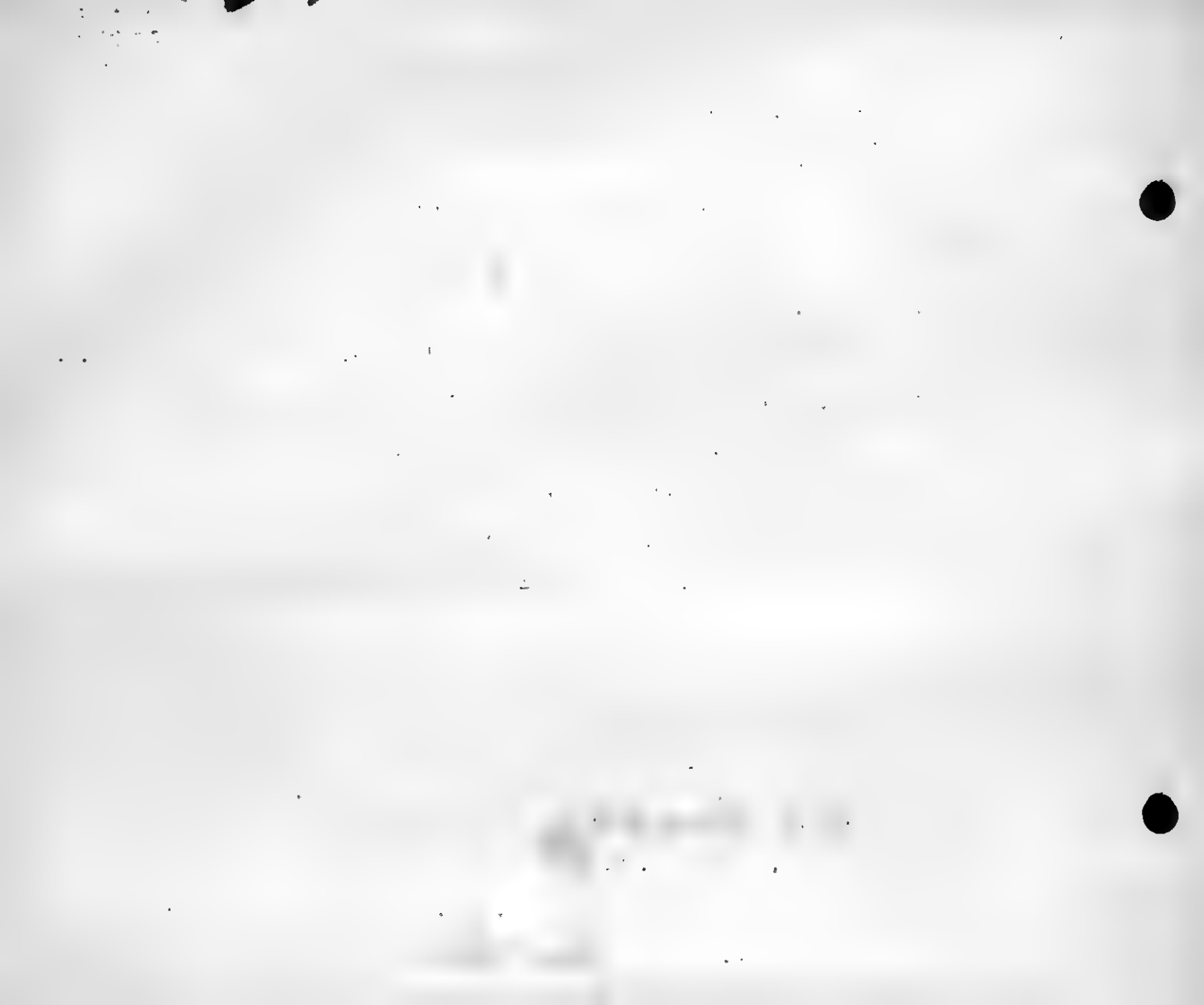
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Towson</u>		c. LENGTH OF STAY IN 1b <u>17 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 24</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>	
e. STREET ADDRESS <u>924 S. Belmord Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>DERNOGA</u> Last <u>DERNOGA</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-10-99</u>
9 AGE in years (last birthday) <u>67</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>Homemaker</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>GURSKI</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>214-54-6895</u>		17. INFORMANT Address <u>Lorraine Daughter, Miller</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO (b) <u>Arteriosclerosis vasculare disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Hypertension - Diabetic gangrene left foot</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-14</u> , 19 <u>67</u> , to <u>7-2</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>7-2</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>M. Isabelle Macguire</u>		22b. DATE SIGNED <u>7-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE SERRA</u>		22d ADDRESS <u>Gr. Balto. Medical Center</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>July 5, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John J. Duda Inc. 2829 Hudson St. Balto. Md.</u>		25a REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09163 Item #2a,b,c & d infor. taken from birth cert. 09163									
1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY Greater Baltimore Medical Center					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					d. STREET ADDRESS 600 E. Joppa Road 6701 North Charles Street				
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle DERR Last DERR					4. DATE OF DEATH Month 7 Day 21 Year 19 67				
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/67		9. AGE (In years last birthday) 0 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard E. Derr					14. MOTHER'S MAIDEN NAME Sharon Lee Bogema				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT from chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyaline membrane disease DUE TO (c) Premature birth-low weight PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/20, 1967 , to 7/21, 1967 , that (I) (we) last saw the deceased alive on 7/21, 1967 , and that death occurred at 6:00 p.m. from the causes and on the date stated above.									
22a. SIGNATURE A. M. Davick, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/21/67		
22c. PHYSICIAN'S NAME (Type) Alan M. Davick, M. D.					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 7/24/67		23c. NAME OF CEMETERY OR CREMATORY Greater Balto. Med. Center		23d. LOCATION (City, town or county) (State) Towson, Maryland		
24. FUNERAL DIRECTOR John E. Adams, M. D.					25a. REC'D BY REGISTRAR John E. Adams		25b. REGISTRAR'S SIGNATURE John E. Adams		
					DATE JUL 26 1967				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY (MD)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY (MD)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2400 Westchester Ave		d. STREET ADDRESS 2400 Westchester Ave	
3. NAME OF DECEASED (Type or print) George HENRY Dietz		4. DATE OF DEATH Month 7 Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/16
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY J. Hopkins Lab.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME George Dietz - Sr.	
14. MOTHER'S MAIDEN NAME Margaret Askar		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-10-5566		17. INFORMANT Mary J. Dietz - 2400 Westchester Ave - Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO 7 x 101 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture Ventricular Aneurysm (c) MYOCARDIAL INFARCTION, Multiple 7 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from 1/23 , 19 50 to 7/9 , 19 67 , that I last saw the deceased alive on 7/9/67 , 19 67 , and that death occurred at — M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Glen Burnie M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 7432 Furnace Br. Rd. E. 7/11/67	
PHYSICIAN'S NAME (Type) R. W. PRICHARD M.D. Glen Burnie, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-14-1967	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie AACo - Md
23. FUNERAL DIRECTOR'S SIGNATURE Edw. P. Mac Nabbs		ADDRESS 301 Frederick Rd - 21228	
24a. REC'D BY REGISTRAR DATE JUL 14 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

09164

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09165											
1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admiss on) a STATE MARYLAND b COUNTY BALTIMORE							
b CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) ARBUTUS				c LENGTH OF STAY IN b				c CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) ARBUTUS			
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5118 SHELBOURNE ROAD 21227				d STREET ADDRESS 5118 SHELBOURNE ROAD 21227				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First EDWIN Middle H. Last DORSEY				4 DATE OF DEATH Month JULY Day 25 Year 1967							
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7/30/96		9 AGE (In years lost birthday) yrs 70		10 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even, retired) Freight Handler				10b KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (State or foreign country) Maryland				12 COUNTRY OF WHAT COUNTRY? USA	
13 FATHER'S NAME Harry C. Dorsey				14 MOTHER'S MAIDEN NAME Annie Lee Francis							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 220-12-8284		17 INFORMANT Address 21227 Mr. Norman Gaither, 5118 Shelbourne Rd.					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Strangulation DUE TO (b) Hanging - self inflicted DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 										INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James N. Frederick M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 7/26/67			
EXAMINER'S NAME (Type) JAMES N. FREDERICK				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) 1311 FRANCIS AVE.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7/29/67		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d LOCATION (City or town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229						25a REC'D BY REGISTRAR DATE JUL 27 1967		25b REGISTRAR'S SIGNATURE James N. Frederick			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09166

09166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbsville		c. LENGTH OF STAY IN 1b 6 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3120 Richwood Avenue		d. STREET ADDRESS 3120 Richwood Avenue	
3. NAME OF DECEASED (Type or print) ORIE HARRIET DOW		4. DATE OF DEATH 7 1 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Bortner		14. MOTHER'S MAIDEN NAME Lena Benschel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-10-1475	
17. INFORMANT Mrs. Muriel Moore		Address 3120 Richwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-2-18-1967 to 7-1-1967 , that (I) (we) last saw the deceased alive on 6-15-1967 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Barth Calin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. BARBU CALIN		22d. ADDRESS 8811 Liberty Rd. Randall	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/5/1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town or county) (State) Woodlawn, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Stansbury Funeral Home		25a. REC'D BY REGISTRAR JUL 5 1967	
ADDRESS Woodlawn, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09167

09167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4107 Colonial Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXX Pikesville</u> d. STREET ADDRESS <u>4107 Colonial Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RICHARD J. DRAGON</u> First Middle Last			4. DATE OF DEATH <u>JULY 29, 1967</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/47</u> XXXXXXXXXXXX		9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Robert Dragon</u>				
14. MOTHER'S MAIDEN NAME <u>Sonia Silberman</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT <u>Robert Dragon--</u> Address <u>Same</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC INSUFFICIENCY</u> (b) <u>CARDIAC ENLARGEMENT</u> (c) <u>AORTIC DILATATION - AND RUPTURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1957</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> , 19 <u>67</u> , and that death occurred at <u>7/29/67</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Alvin Stambler</u>				22b. DATE SIGNED <u>7/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ALVIN STAMBLER</u>				22d. ADDRESS <u>6941 REISTERSTOWN RD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oheb Shalom Cong.</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC. 6010 Reist. Rd.</u>					
25a. REC'D BY REGISTRAR DATE <u>AUG 3 1967</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		e. STREET ADDRESS 1716 Eutaw Place	
3. NAME OF DECEASED (Type or print) VIRGINIA XXXX DRUMGOLE (DRUMGOLD)		4. DATE OF DEATH Month July Day 22 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan 9, 1921
9. AGE (In years last birthday) 46 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Smith		14. MOTHER'S MAIDEN NAME Corrina Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Bettie Peace		Address 310 Jones Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic Heart Disease 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i> EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED July 22, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-26-67	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	23d. LOCATION (City or Town) (County) (State) Arbutus, Maryland
24. FUNERAL DIRECTOR Arlington S. Phillips		25a. REC'D BY REGISTRAR JUL 25 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09169

CERTIFICATE OF DEATH

09169

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 9 1/2 mo.		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mount Wilson State Hospital		d. STREET ADDRESS 426 E. Pratt Str		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN CLIFTON DUKE		4. DATE OF DEATH Month 7 Day 25 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12. 17. 1904	9. AGE (In years last birthday) yrs 62	IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME W. T. DUKE		14. MOTHER'S MAIDEN NAME LENA PARKER		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. Peace-time 224-09-6476		17. INFORMANT Records, Mount Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3 years DUE TO (+) DUE TO (+)					INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of lung					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10. 11 , 19 66 , to 7. 25 , 19 67 , that (I) (we) last saw the deceased alive on 7. 25 , 19 67 , and that death occurred at 3:10 PM , from causes and on the date stated above.					
22a. SIGNATURE Wm. Newcomer		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7. 25. 67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-29-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suffolk, Va.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK 21222	
c. LENGTH OF STAY in 1b 37		d. STREET ADDRESS 2638 LIBERTY PARKWAY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2638 LIBERTY PARKWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE JAMES DUNLAP		4. DATE OF DEATH JULY 4, 1967	
5. SEX MALE CAUCASIAN	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1905 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLANGER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NORMAN DUNLAP		14. MOTHER'S MAIDEN NAME CECEKIA BYRD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213/09/1620	
17. INFORMANT ANNA A. DUNLAP		Address AS IN #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) A-S-C-V-DISEASE DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		22. DATE SIGNED 7/5/67	
EXAMINER'S NAME (Type) M.B. DAVIS MD - 6800		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/7/1967	
23c. NAME OF CEMETERY OR CREMATORY CANLAWA		23d. LOCATION (City, town or county) (State) BALTO. CO. MD.	
24. FUNERAL DIRECTOR W. Burke Bradley, Dundalk, Md.		25a. REC'D BY REGISTRAR DATE JUL 10 1967	
		25b. REGISTRAR'S SIGNATURE James J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09171

CERTIFICATE OF DEATH

09171

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>BALTIMORE</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWSON		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWSON			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				d STREET ADDRESS <u>1207 Robin Hood Circle</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Carl August Edberg</u>				4 DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-2-01</u>	9 AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>PRUDENTIAL LIFE INS. CO.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12 COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles R. Edberg</u>				14 MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16 SOCIAL SECURITY NO. <u>214-03-3013</u>		17 INFORMANT <u>LILLIAN A. EDBERG</u> <u>(Patients Chart)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic and hypertensive cardiovascular disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour : a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that <u> </u> (this hospital) attended the deceased from <u>6-28</u> , 19 <u>67</u> , to <u>7-6</u> , 19 <u>67</u> , that (1) <u>we</u> last saw the deceased alive on <u>7/6</u> 19 <u>67</u> and that death occurred at <u>12-10AM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Dipak K. Mattik</u>				22b DATE SIGNED <u>7.6.67</u>		22c PHYSICIAN'S NAME (Type) <u>Dipak K. Mattik</u>	
22d ADDRESS <u>Greater Balto. Medical Center</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/8/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d LOCATION (City or Town) <u>Baltimore, Md.</u>		(County) (State)	
24 FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>				25a REC'D BY REGISTRAR <u> </u>		25b REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>				DATE <u>JUL 7 1967</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09172

09172

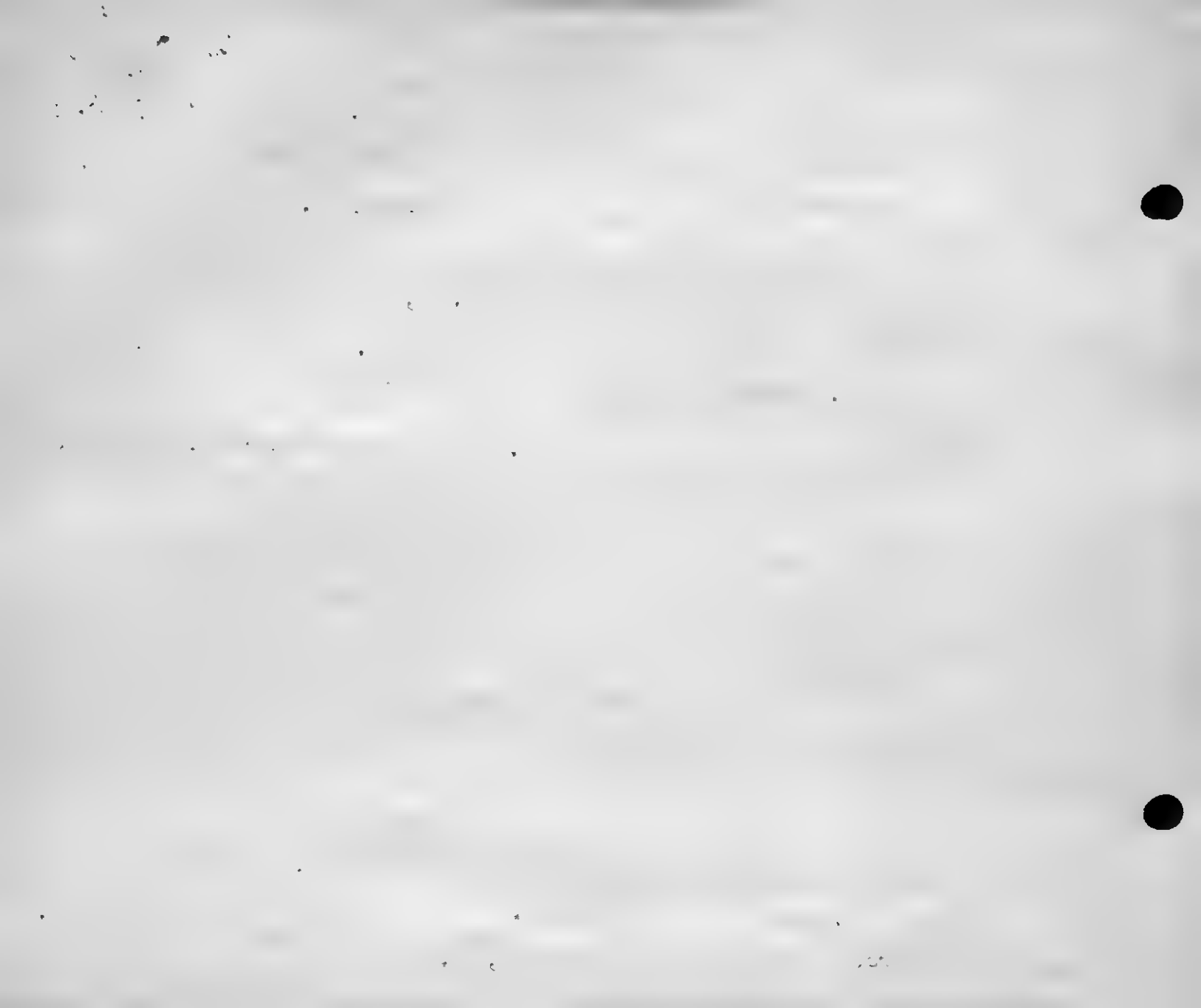
1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 5 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTIMORE MEDICAL CENTER		d. STREET ADDRESS 1203 CATHEDRAL STREET	
3 NAME OF DECEASED (Type or print) GLENNA PAULINE ELBON		4 DATE OF DEATH Month 7 Day 8 Year 1967	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-14
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR: Months 7 Days 8 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANALYSIS TECH		10b. KIND OF BUSINESS OR INDUSTRY SECURITY AGENCY	
11 BIRTHPLACE (County & State or foreign country) SAGO - W. VA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GROVER CLEVELAND ELBON		14 MOTHER'S MAIDEN NAME SIMMONS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16 SOCIAL SECURITY NO 236-01-8130	
17 INFORMANT Address		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Carcinoma Right Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/29/1967 to 7/8/1967 that (I) (we) last saw the deceased alive on 7/8/1967 and that death occurred at 11:00 P.M. from causes and on the date stated above.			
22a SIGNATURE Tom Poliness M.D.		22b. DATE SIGNED 8-7-67	
22c PHYSICIAN'S NAME (Type) TOM POLINESS		22d ADDRESS % G.B.M.C. 6701 N. CHARLES ST. BALD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-12-67	
23c. NAME OF CEMETERY OR CREMATORY Meadowdale Park		23d. LOCATION (City or town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Felix C. ...		25a. RECEIVED BY REGISTRAR DATE JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09173		09173									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale 21207</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8331 Liberty Rd</u>				d. STREET ADDRESS <u>8331 Liberty Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>AGNES EMMEL</u>				4. DATE OF DEATH <u>7-26-1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto; Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>William H. Aestor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hanafin</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Matina Zopf, Old Court Rd. Woodstock, Md</u> Address <u>21163</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO (b) <u>Hypertensive Arteriosclerotic CVD</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7-26-1967</u> to <u>7-26-1967</u> , that (I) (we) last saw the deceased alive on <u>7-26-1967</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Cesar Valle Couervo</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-26-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAUERO</u>				22d. ADDRESS <u>8629 Liberty Rd</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		23d. LOCATION (City, town or county) (State) <u>3310 Taylor Ave; Balto; Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				ADDRESS <u>21133</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u></u>			



09176

CERTIFICATE OF DEATH

09174

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore Lutherville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
c. LENGTH OF STAY IN 3b Years		d. STREET ADDRESS 8 Felton Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8 Felton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard A Evoy		4. DATE OF DEATH Month Day Year July 13, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1894
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min 15 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY John Deere Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Evoy		14. MOTHER'S MAIDEN NAME Mary Ellen Justiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 213-03-6786	
17. INFORMANT Mrs. Margaret E. Evoy		Address 8 Felton Rd. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardiovascular Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/16/66 to 7/13/67 , that (I) (we) last saw the deceased alive on 6/20/67 , and that death occurred at 6:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles J. Blazek		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) CHARLES J. BLAZEK		22d. ADDRESS 1116 St. Paul St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d filed 7/25/67

09175

CERTIFICATE OF DEATH

09175

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d STREET ADDRESS <u>2601 E. Fayette St.</u>	
3 NAME OF DECEASED (Type or print) <u>Emme Virginia Foster</u>		4 DATE OF DEATH <u>7/21/67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>U</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-6-74</u>
9a AGE (In years last birthday) <u>88</u> yrs		9b IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Calvert Co.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>Alexandria Burkmaster</u>		14 MOTHER'S MAIDEN NAME <u>Amelia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Patient's Chart</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY.			
IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u>			
DUE TO (b) <u>massive ep. I. bleeding</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>6.22.</u> , 19 <u>67</u> , to <u>7.21.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7.21.</u> 19 <u>67</u> , and that death occurred at <u>11:45 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Sybak Kumar Mallik.</u>		22b DATE SIGNED <u>7.22.67.</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>July 25, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road</u>		25a REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b REGISTRAR'S SIGNATURE		DATE <u>JUL 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09176

CERTIFICATE OF DEATH

09176

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6660 Loch Hill Road		d. STREET ADDRESS 6660 Loch Hill Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Ethel M Fetherolf		4. DATE OF DEATH Month July Day 3 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16th 1900-66 yrs.
9 AGE (In years lost birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	11. BIRTHPLACE (County & State, or foreign country) Medford, Wis.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Morrow	
14. MOTHER'S MAIDEN NAME Enameline McKey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---	
16 SOCIAL SECURITY NO 214-26-7748		17 INFORMANT Address JL-Mrs. Ethel F. Mills	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-sclerotic Heart Disease with atrial fibrillation DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Completed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Dec., 1966 , to July 3rd, 1967 , that (I) (we) last saw the deceased alive on July 3rd, 1967 , and that death occurred at _____ M, from causes on and on the date stated above.	
22a. SIGNATURE Dr. Cesar J. Pellerano M.D.		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) Dr. Cesar J. Pellerano		22d. ADDRESS 1311 Glenmont Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/6/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home Inc. ADDRESS 6500 York Road-21212		25a. REC'D BY REGISTRAR DATE JUL 7 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Jones			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 File #1391 8/27/67
09177
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
03177

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove Hospital		e STREET ADDRESS 1702 Lombard Street	
3 NAME OF DECEASED (Type or print) FLORINE H. FIELDS		4 DATE OF DEATH Month July Day 23 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years lost birthday) 43 42 yrs
9 US. At OCCUPATION (Give kind of work done during most of working life, even if retired) SECRET		10b KIND OF BUSINESS OR INDUSTRY ICE CREAM CO.	
11 BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME LATE CARTER FIELDS		14 MOTHER'S MAIDEN NAME MARY E. BOARDWINE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT HERB MOORE MIDDLEBERG VA		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty infiltrate of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 23, 1967	
EXAMINER'S NAME (Type)		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF July 24, 1967	23c NAME OF CEMETERY OR CREMATORY LEBANON	23d LOCATION (City or Town) (County) (State) LEBANON, VIRGINIA
24. FUNERAL DIRECTOR WITKE 4101 EDMONDSON AVE MD.		25a REC'D BY REGISTRAR DATE JUL 27 1967	
		25b REGISTRAR'S SIGNATURE [Signature]	



CERTIFICATE OF DEATH

09178

09178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>		d. STREET ADDRESS <u>4431 Alan Drive</u>	
3. NAME OF DECEASED (Type or print) <u>John T. Fieldseth</u>		4. DATE OF DEATH <u>7/24/67</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u>		8. DATE OF BIRTH <u>6/1/1887</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thorwald Fieldseth</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Boedeker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>348-12-2251</u>	
17. INFORMANT <u>R. Taylor McLean, Campbell Bldg, Towson</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ASCVD</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/24/64</u> , 19 <u> </u> , to <u>7/24/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>7/23/67</u> , 19 <u> </u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Mahoney</u> M.D.		22b. DATE SIGNED <u>7/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Mahoney, M.D.</u>		22d. ADDRESS <u>201 E. Joppa Rd. Towson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/26/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>JUL 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jorgensen</u>			

09179

CERTIFICATE OF DEATH

09179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY in it <u>21 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2707 Maple Ave</u>		d. STREET ADDRESS <u>2707 Maple Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond R Fiorenino</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>8</u> Hours <u>12</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAILOR shops</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicola Fiorentino</u>		14. MOTHER'S MAIDEN NAME <u>Marie MAROLLA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-05-6129</u>	
17. INFORMANT <u>Josephine Fiorentino Sone</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio Vasc. Dis.</u> with <u>Cardiac Asthma</u> Old <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2x1</u> (b) <u>due to</u> (c) <u>due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital attended the deceased from <u>160</u> , 19 <u>65</u> to <u>July</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>July 3</u> , 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>F T KASIK</u>		22b. DATE SIGNED <u>7/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F T KASIK</u>		22d. ADDRESS <u>9005 Harford Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 15 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>C. F. EVANS</u>		25a. REC'D BY REGISTRAR <u>JUL 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		DATE	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 7 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09180

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Turners Station		c. LENGTH OF STAY IN 1b Baltimore, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 620 Peach Orchard Lane		d. STREET ADDRESS 620 Peach Orchard Lane	
3 NAME OF DECEASED (Type or print) THEODORE ROOSEVELT FLOOD		4. DATE OF DEATH Month July Day 24 Year 1967	
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 17, 1907
9 AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Bedford County, Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Flood		14 MOTHER'S MAIDEN NAME Kate Thomas	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.	
17. INFORMANT Mollie Palmer, 620 Peach Orchard Ln.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition Dehydration DUE TO (b) ACHD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C Patterson M.D.		22. DATE SIGNED 7/27/67	
NAME (Type) THEO. C PATTERSON		23a. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-28-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. ADDRESS Charles R. Law 802 Madison Ave.	
24. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.		25a. REC'D BY REGISTRAR DATE AUG 1 1967	
25b. REGISTRAR'S SIGNATURE Charles R. Law			

James Flood

No

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09181

1 PLACE OF DEATH a <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a STATE <u>Maryland</u> b COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d STREET ADDRESS <u>2810 Elsinore Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Maxwell P. Foote</u>		4 DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-2-1919</u>
9 AGE (In years last birthday) <u>48</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Chauffeur</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Maxwell P. Foote</u>		14 MOTHER'S MAIDEN NAME <u>Kenneth P. Foote</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>II</u>		16 SOCIAL SECURITY NO _____	
17 INFORMANT <u>Sarah Foote Byrd,</u>		Address _____	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>Arteriosclerotic Cardiovascular Disease</u> IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____ (b) _____ DUE TO _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u>		22 DATE SIGNED <u>7/24/67</u>	
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>		23a LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
23b DATE THEREOF <u>7-27-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat.</u>	
24 FUNERAL DIRECTOR <u>Charles R. Law 802 Madison</u>		25a REC'D BY REGISTRAR DATE <u>7 25 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles R. Law</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

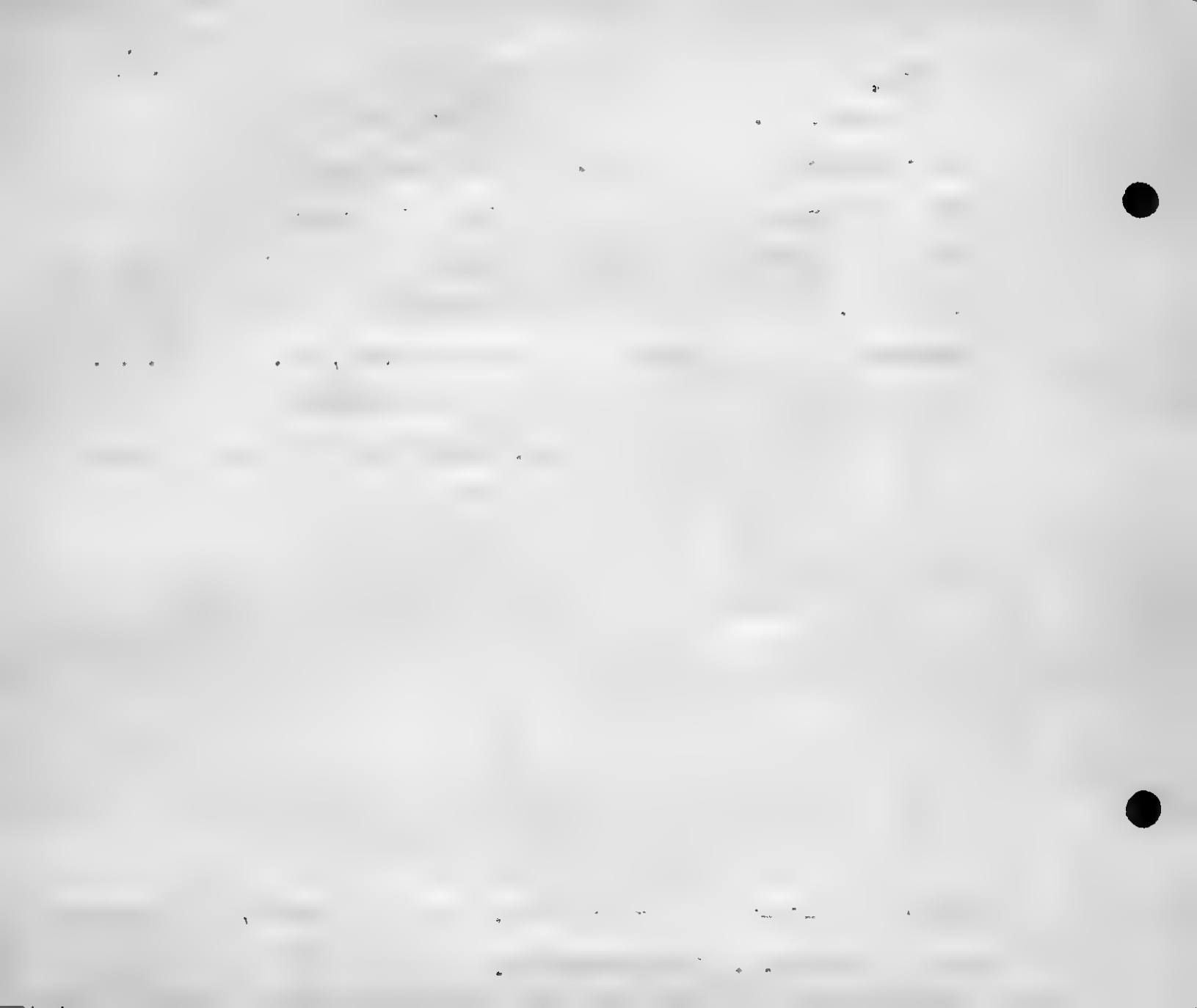
CERTIFICATE OF DEATH

09182

09182

1. PLACE OF DEATH a. COUNTY BALTO. CO. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY in lb 52 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1018 "I" Street				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point d. STREET ADDRESS 1018 "I" Street			
3. NAME OF DECEASED (Type or print) MARY WILLIE FOSTER				4. DATE OF DEATH 7 28 19 67			
5. SEX F. N.		6. COLOR OR RACE F. N.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Drakes Branch, Va.	
13. FATHER'S NAME CHARLIE LEWIS				14. MOTHER'S MAIDEN NAME FANNIE LEWIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. James Foster				Address 1018 I Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/65 , 19 to 7/28/67 , 19 , that (I) (we) last saw the deceased alive on 7/27/67 , 1967 , and that death occurred at 54 M, from the causes and on the date stated above.							
22a. SIGNATURE Theo C Patterson				22b. DATE SIGNED 7/28/67			
22c. PHYSICIAN'S NAME (Type) THEO. C. PATTERSON				22d. ADDRESS 105 Main St 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-31-67		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION (City, town or county) (State) Arbutus, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MORTON & DYETT F.H. 1701 Laurens St.				25a. REC'D BY REGISTRAR JUL 31 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

09188

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3626 Oak Ave</u>		d. STREET ADDRESS <u>3626 Oak Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>FRANCIS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1967</u>	
SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 8, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER - Telephone Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARION, VIRGINIA</u>	
13. FATHER'S NAME <u>EVERETT FRANCIS</u>		14. MOTHER'S MAIDEN NAME <u>CORA JOHNSTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes -</u>		16. SOCIAL SECURITY NO. <u>212-10-0822</u>	
17. INFORMANT <u>TANET G. FRANCIS - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASTROCYTOMA OF BRAIN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>17 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1954</u> to <u>JULY 7, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>JULY 6, 1967</u> , and that death occurred at <u>8:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Goldstein</u>		22b. DATE SIGNED <u>JULY 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN GOLDSTEIN</u>		22d. ADDRESS <u>6001 PARK HEIGHTS BALTO. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery - Baltimore, MD</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>ELLIS WORTH ARMACAST - 4600 Liberty Heights Ave</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

09184

09184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 15 Box 58 - Baltimore, Md.</u>	
c. LENGTH OF STAY IN lb <u>7 days</u>		d. STREET ADDRESS <u>Rt. 15 Box 58</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Earle Fresh</u>		4. DATE OF DEATH Month Day Year <u>July 20 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1911</u>
9. AGE (in years last birthday) <u>56 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Thomas Fresh</u>		14. MOTHER'S MAIDEN NAME <u>Heck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-14-05-4578 ETTA FRESH</u>	
17. INFORMANT <u>(SAMUE)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u>Pericardial effusion</u> DUE TO (c) <u>Carcinoma of lung-treated with radiation therapy</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/19, 1967</u> to <u>7/20, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/20, 1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rudiger Breitenecker</u> M.D.		22b. DATE SIGNED <u>July 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rudiger Breitenecker, M. D.</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Carl E. Cheneveth</u>		25a. REC'D BY REGISTRAR <u>3617 Chestnut Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 25 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09185

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN IB Maryland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Majestic Distillery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2030 E. Biddle Street	
3. NAME OF DECEASED (Type or print) First VAN Middle LEYAN Last GARDNER		4. DATE OF DEATH Month July Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5 yrs
9. AGE (In years lost birthday) 55 yrs		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.	
10a. US. AC. OCCUPATION (Give kind of work done during most of working life, even if retired) Distillery		10b. KIND OF BUSINESS OR INDUSTRY Distillery	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME St. + + + + +		14. MOTHER'S MAIDEN NAME St. + + + + +	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2-2-2-2-2-2-2-2-2-2	
17. INFORMANT AMY GARDNER 2-2-2-2-2-2-2-2-2-2		Address 2030 E. Biddle St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect an <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 3, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county) 2030 E. Biddle St	
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVED	23b. DATE THEREOF 7-1-67	23c. NAME OF CEMETERY OR CREMATORY St. + + + + +	23d. LOCATION (City or town) (County) (State) St. + + + + +
24. FUNERAL DIRECTOR St. + + + + +		25a. REC'D BY REGISTRAR JUL 5 1967	
ADDRESS St. + + + + +		25b. REGISTRAR'S SIGNATURE St. + + + + +	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09186

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN TB <u>1 Mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2130 Southland Rd</u>		d. STREET ADDRESS <u>2130 Southland Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>MAY</u> Last <u>GAYLORD</u>		4 DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-25-1880</u>
9 AGE (In years lost birthday) <u>87</u> yrs		10 IF UNDER 1 YEAR Months <u>23</u> Days <u>13</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, give retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Dayton, Ohio</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>ISAAC YOUNG</u>		14. MOTHER'S MAIDEN NAME <u>WARNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>274-36-0040</u>	
17 INFORMANT <u>Dorothy Elliott</u>		Address <u>2130 Southland Rd</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> DUE TO <u>Arteriosclerotic Cardiac Vascular Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Cardiac Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSES WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1311 Francis Ave. Balt. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>7-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>	
24 FUNERAL DIRECTOR <u>Elsworth Armbrust</u>		25a. REGD BY REGISTRAR <u>JUL 28 1967</u>	
ADDRESS <u>4600 Liberty Heights Ave</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

7/24/67

1311 Francis Ave.

Balt. Md

22. DATE SIGNED

25b. REGISTRAR'S SIGNATURE

DATE JUL 28 1967

09187

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown P.O.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>Dover Road</u>	
3. NAME OF DECEASED (Type or print) <u>Alan Clifford Gent</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1889</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Orrick Gent</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-0696</u>	
17. INFORMANT <u>Family records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>hypertension, arteriosclerosis general</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>05-7-66</u> , 19 <u> </u> , to <u>07-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-3-67</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell</u>		22b. DATE SIGNED <u>7-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Reisterstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grace-Falls Rd. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Reisterstown, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REG'D BY REGISTRAR <u>JUL 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James G. Saffell</u>		25c. REGISTRAR'S NAME <u>James G. Saffell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

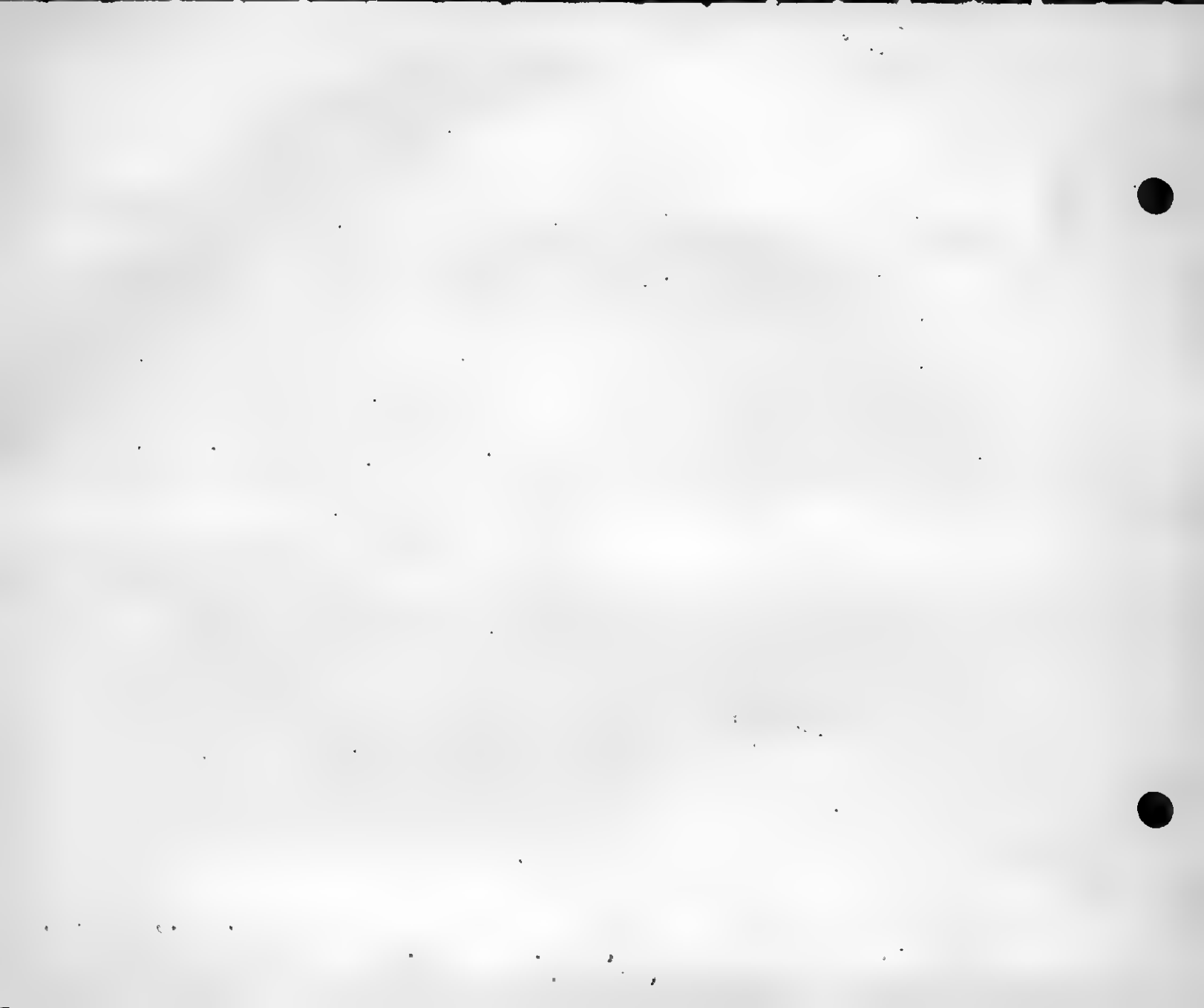
VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

20188		55183	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in 1b <u>—</u>		d. STREET ADDRESS <u>3607 Loch Raven BLVD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gwendolyn Delia German</u>		4. DATE OF DEATH <u>JULY 30 1967</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>cau</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/23/12</u> 9. AGE (in years last birthday) <u>55</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Matthew Joseph white</u> 14. MOTHER'S MAIDEN NAME <u>DELIAR ARUEY</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>212-18-4765</u> 17. INFORMANT <u>FREDERICK A. GERMAN (SAME)</u> Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Breast carcinoma with liver metastasis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>0300</u> p.m. <u>1967</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>5/25, 1967</u> to <u>7/30, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 30 1967</u> , and that death occurred at <u>11:30 M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Rahim M. Bassiri</u> 22b. DATE SIGNED <u>7/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>RAHIM M. BASSIRI</u> 22d. ADDRESS <u>G.B.M.C. - TOWSON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/2/1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>		24. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09189

09189

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN TB Life			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 9 East Overlea Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Sophia Veronica Gerst			4. DATE OF DEATH Month Day Year 7 1 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1893	9. AGE (in years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John F. Suhre			14. MOTHER'S MAIDEN NAME Sophia Deuerling		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO None	17. INFORMANT Mrs Rose Hensel 266 1/2 Holly Neck Rd. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas 157X DUE TO (b) Duodenal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour " a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/6/ , 19 67 , to 7/1/ , 19 67 , that (I) (we) last saw the deceased alive on 7/1/ , 19 67 , and that death occurred at 11 p M, from causes and on the date stated above.					
22a. SIGNATURE Jaime Ambrad		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 7-1-67		
22c. PHYSICIAN'S NAME (Type) JAIME AMBRAD		22d. ADDRESS 7620 York Rd., Towson, 21204, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/5/67	23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cem.	23d. LOCATION (City or Town) (County) (State) Fullerton Balto Co Md.		
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE JUL 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

09190

CERTIFICATE OF DEATH

09190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp.</u>		d. STREET ADDRESS <u>1362 Sudvale ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>Donis</u> Middle <u>Glaser</u> Last <u>Glaser</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>4-</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-07</u> 59 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Joseph Lerner</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL Shor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	17. INFORMANT <u>Hospital Record</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic of CA</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>of breast</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-26-</u> 19 <u>66</u> , to <u>7-4-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-4-</u> 19 <u>67</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. LAI</u>		22b. DATE SIGNED <u>7/4/67</u>	22c. PHYSICIAN'S NAME (Type) <u>Dr. LAI</u>
22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>		22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANSHE NESTNA</u>	23d. LOCATION (City or Town) (County) (State) <u>ROSEDALE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOI LEVINSON & BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 16 Howard Ave					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 16 Howard Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Annie Middle L Last Glen					4. DATE OF DEATH Month July Day 2 Year 19 67				
5 SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/1871		9. AGE (In years last birthday) 96 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unkown Diamond					14. MOTHER'S MAIDEN NAME unkown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 214-54-2076		17. INFORMANT Mr. John Glen		Address 16 Howard Ave - 21228	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Arteriosclerotic Cardio-Vasc. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 1537									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-6-1946 to 7-2-1967 , that (I) (we) last saw the deceased alive on 7-2-1967 , and that death occurred at 9 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Wilmer K. Gallagher M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher					22d. ADDRESS 6209 Frederick Ave. Balt. 21228 Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) Baltimore, City (State) Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Son ADDRESS North & Pa. Avenues					25a. REC'D BY REGISTRAR DATE JUL 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

09192

CERTIFICATE OF DEATH

09192

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm. sign) a. STATE MARYLAND b. COUNTY ---	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c LENGTH OF STAY IN 1b .5 1/2 YEARS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME		e STREET ADDRESS 423 S. BALTA LOU ST	
3 NAME OF DECEASED (Type or print) IDA CATHERINE GLOSS		4 DATE OF DEATH Month JULY Day 4 Year 19 67	
5 SEX FE	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/3/1889
9 AGE (In years last birthday) 78 yrs		10 IF UNDER 1 YEAR Months --- Days --- Hours --- Min ---	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME HENRY G. MAHR		14. MOTHER'S MAIDEN NAME MARY DIETZ	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO ---	
17 INFORMANT MASONIC HOME RECORDS		Address ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Compensations DUE TO AS CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) --- (c) ---			INTERVAL BETWEEN ONSET AND DEATH 6 to 7 months 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) ---
20f (City or town) ---		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Doc , 19 39 to July , 19 67 , that (I) (we) last saw the deceased alive on 1 July , 19 67 , and that death occurred at 6:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4 July 1967
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS Cockeysville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF July 7, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Western	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.
24 FUNERAL DIRECTOR Wm Cook-Brooks Towson		25a. REC'D BY REGISTRAR JUL 10 1967	
ADDRESS Towson Md		25b. REGISTRAR'S SIGNATURE ---	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09193

CERTIFICATE OF DEATH

09193

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b COUNTY <u>—</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN lb <u>—</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d STREET ADDRESS <u>3626 Fords Lane, Apt 3C</u>	
3 NAME OF DECEASED (Type or print) <u>FRANK GOLDENBERG</u>		4 DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>DEC. 17, 1888</u>
9 AGE (In years last b rthday) <u>78</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a USUAL OCCUPATION (Give kind of work done during past working life, even if retired) <u>ENGINEER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>POWER & LIGHT CO.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE, MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13 FATHER'S NAME <u>GABRIEL GOLDENBERG</u>		14 MOTHER'S MAIDEN NAME <u>LIBBY MAGGIDMAN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>212-07-2037A</u>	
17 INFORMANT <u>Mrs. Myra Roseman, 2419 Hunt Drive</u>		Address <u>#9</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular</u> DUE TO (b) <u>Disease with Cerebral Degeneration</u> DUE TO (c) <u>over 2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recurrent Psychotic Stenosis due to Peptic Ulcer</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 196 <u>5</u> , to <u>15 July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 July</u> 19 <u>67</u> , and that death occurred at <u>3:20 A.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>Lauriston L. Keown M.D.</u>		22b DATE SIGNED <u>15 July 67</u>	
22c PHYSICIAN'S NAME (Type) <u>DR. LAURISTON KEOWN</u>		22d ADDRESS <u>431 E. LAKE AVENUE</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>7/16/67</u>		23b DATE THEREOF <u>Burial</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Maryland Lodge</u>		23d LOCATION (City or Town) (County) (State) <u>Rosedale, Md.</u>	
24 FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>		25a REC'D BY REGISTRAR <u>JUL 18 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Re: before ad.) a. STATE Maryland b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Md 21210 d. STREET ADDRESS 4318 Roland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN B GORDON			4. DATE OF DEATH Month July Day 3 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1906		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. General Directory C&P Telephone Co.				10b. KIND OF BUSINESS OR INDUSTRY Texas		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emory V. Gordon					14. MOTHER'S MAIDEN NAME Ella Hill				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 058-05-6547		17. INFORMANT Mrs. Anne M. Gordon		Address (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 2 HRS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 67 , to 7/3 , 19 67 , that (I) was last saw the deceased alive on 7/3 , 19 67 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE John M. Scott				22b. DATE SIGNED 7/3/67					
22c. PHYSICIAN'S NAME (Type) JOHN M. SCOTT				22d. ADDRESS 600 W. BELVEDERE AVE BALTIMORE, MD 21210					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/6/1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.						25a. REC'D BY REGISTRAR JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



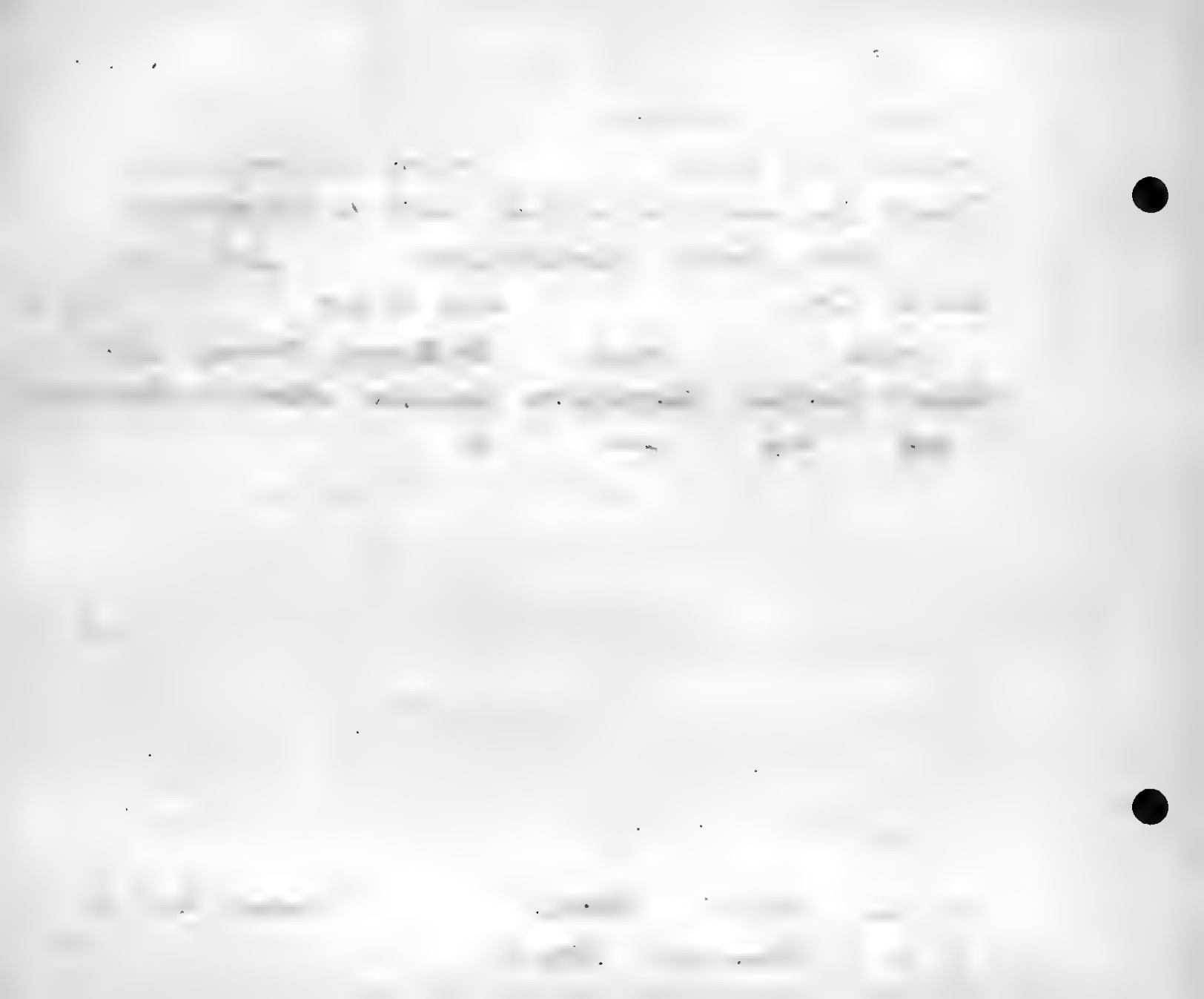
CERTIFICATE OF DEATH

20195

1104 2 2000 1474-1475

091997

1. PLACE OF DEATH a. COUNTY G.B.M.C.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Baltimore, Maryland		b. COUNTY 4107 Eierman Avenue 21206	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 21204		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER Baltimore Medical Center				d. STREET ADDRESS 16791 N. CHARLES ST.	
3. NAME OF DECEASED (Type or print) Baby GIRL		First GORSCHBOTH		Last —	
5. SEX Female		6. COLOR OR RACE CAU.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 25, 1967		9. AGE (In years last birthday) 19		10. DATE OF DEATH July 26, 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Carroll Gorschboth		14. MOTHER'S MAIDEN NAME Lorraine Alberta Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT —	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity and low birth weight (c) —		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from 7/25 , 19 67 to 7/26 , 19 67 , that (I) (we) last saw the deceased alive on 7/26 , 19 67 , and that death occurred at 2:00 PM , from the causes and on the date stated above.					
22a. SIGNATURE Alan M. Savick		22b. DATE SIGNED 7/26/67		22c. PHYSICIAN'S NAME (Type) —	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 7/29/67		23c. NAME OF CEMETERY OR CREMATORY G.B.M.C.	
23d. LOCATION (City, town or county) (State) Towson, Md. 21204		24. FUNERAL DIRECTOR John E. Adams M.D. G.M.C.		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

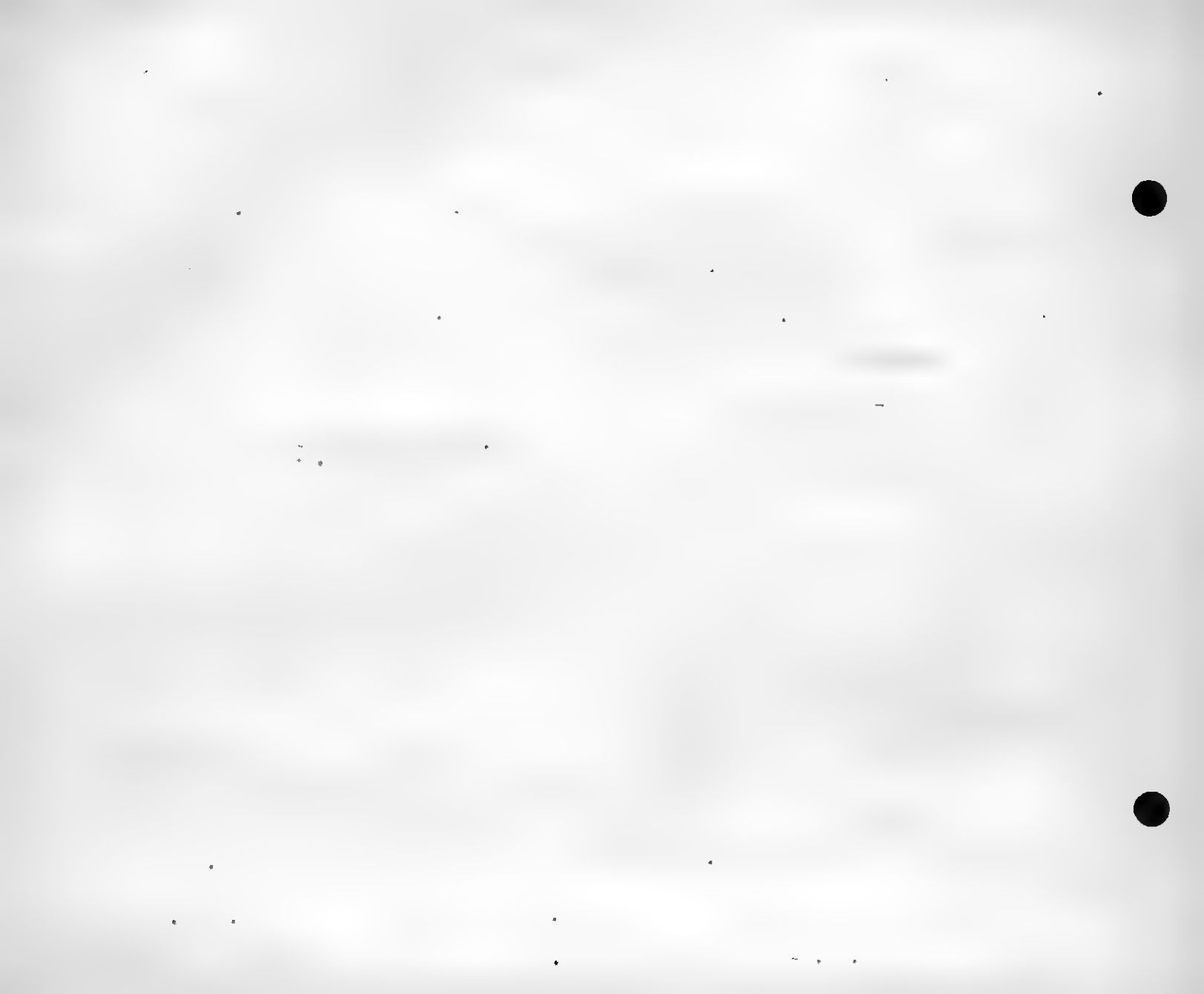
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

29196

29196

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____	
c. LENGTH OF STAY IN TB _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines Nursing Home		d. STREET ADDRESS 4114 Edmondson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma L. Gosnell First Middle Last		4. DATE OF DEATH Month Day Year July 3, 1967	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 14, 1898
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME --- Huthwelker		14. MOTHER'S MAIDEN NAME _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Mr. Charles Gosnell 308 Seminole Ave. - 21228		Address _____	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TITPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from June 19, 1967 to 3 July, 1967 , that (I) (we) last saw the deceased alive on 3 July 1967 , and that death occurred at 8:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE William J. Bryson		22b. DATE SIGNED 5 July 67	
22c. PHYSICIAN'S NAME (Type) William J. Bryson		22d. ADDRESS 4605 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/7/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE JUL 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09197

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown 1.0.</i>		c. LENGTH OF STAY IN 1b <i>76 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Falls Rd</i>		d. STREET ADDRESS <i>Falls Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Griffith</i> Last <i>Griffith</i>		4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>26 January 1891</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewifery</i>		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) <i>76</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Harrisburg, Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William David Griffith</i>		14. MOTHER'S MAIDEN NAME <i>Emma Given</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>215-42-7979</i>	
17. INFORMANT <i>Sister - Margaret Griffith - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO (b) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>over 20 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1976</i> to <i>July 1967</i> , that (I) (we) last saw the deceased alive on <i>20 June 1967</i> , and that death occurred <i>6:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>3 July 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Old Ironpowder Meeting House</i>	23d. LOCATION (City, town or county) (State) <i>Cockeysville, Md</i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Tomson, Maryland</i>		25a. REC'D BY REGISTRAR <i>JUL 10 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

09198

CERTIFICATE OF DEATH

09198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Cockeysville 21030 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Greenway & Falls Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Earl Guetler		4. DATE OF DEATH Month July Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1918
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min 22	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Routing Lane Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Fairlanes, Inc.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George I. Guetler		14. MOTHER'S MAIDEN NAME Ninnie Oldham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 11	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinomatosis, primary in lung		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from July 13, 1967 , to July 22, 1967 , that he (we) last saw the deceased alive on July 22, 1967 , and that death occurred at 7:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED July 22, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7600 York Road, Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gruid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR JUL 26 1967	
		25b. REGISTRAR'S SIGNATURE John Burns' Sons	

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CERTIFICATE OF DEATH

09199

09199

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton c. LENGTH OF STAY IN "b" 87 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton, Md. d. STREET ADDRESS Monkton, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Grace Slade Guthrie First Middle Last		4. DATE OF DEATH July 24, 1967 Month Day Year	
5 SEX F.	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1879 9. AGE (in years) 87 10th birthday yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Monkton, Md.
13 FATHER'S NAME Alexander Guthrie		14. MOTHER'S MAIDEN NAME Catherine Lanus	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO.	
17. INFORMANT Florence Guthrie, Monkton, Md. 21111 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary failure DUE TO (b) Arterio sclerosis Cardio Vascular Disease DUE TO (c) Arterio sclerosis Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 yr
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 67 , to 7-24 , 19 67 that (I) (we) last saw the deceased alive on 7-23 , 19 67 , and that death occurred at 12:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Herbert Mueller		22b. DATE SIGNED 7-25-67	
22c. PHYSICIAN'S NAME (Type) C. HERBERT MUELLER JR.		22d. ADDRESS PARKTON, Md. 21126	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 26, 67	23c. NAME OF CEMETERY OR CREMATORY Clynmalira	23d. LOCATION (City or Town) (County) (State) Baltimore, Co. Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 ADDRESS		25a. REC'D BY REGISTRAR JUL 31 1967 OATE	
		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

09200

09200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb Baltimore 21234			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 9535 Powderhorn Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) George First Middle Last HAASE			4. DATE OF DEATH Month Day Year July 27, 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 22, 1903	9 AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY Kelly		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Gene Croucher		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Gene Haase Address 9535 Powderhorn	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured abdominal aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 27, 19 67 , to July 27, 1967 , that (I) (we) last saw the deceased alive on July 27, 19 67 , and that death occurred at 11:30M , from causes and on the date stated above.					
22a. SIGNATURE Frank A. Faraino		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED July 27, 1967
22c. PHYSICIAN'S NAME (Type) Frank A. Faraino, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL CREMATION REMOVAL Specify	23b. DATE THEREOF 7/30/67	23c. NAME OF CEMETERY OR CREMATORY Calverwood	23d. LOCATION (City or town) (County) (State) Balto		
24. FUNERAL DIRECTOR PA DeLmann		25a. REC'D BY REGISTRAR 6067 Hayford Rd		25b. REGISTRAR'S SIGNATURE Charles Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09201

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Md. b COUNTY Alleg.			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.			c LENGTH OF STAY in 18 14 yrs		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d STREET ADDRESS 20 Main St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First James Middle Peter Last Habeeb				4 DATE OF DEATH Month July Day 6 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-12-29		9 AGE (in years birthday) yrs 37	IF UNDER 1 YEAR Months 3 Days 1 Hours 1 Min 1	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Keyser, W. Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph F. Habeeb				14. MOTHER'S MAIDEN NAME Nettie Slailey			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16 SOCIAL SECURITY NO none		17. INFORMANT Address Rosewood St. Hosp. Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to bolus of food in larynx DUE TO (b) Mental Deficiency DUE TO (c) Spastic quadriplegia- Chr. Osteomyelitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH 15 min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Spastic quadriplegia- Chr. Osteomyelitis							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none					
20c TIME OF INJURY Month, Day Year 5:50 p.m. 7-6-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, place, etc.) Rosewood St. Hosp		20f (City or town) (County) (State) Owings Mills Balto Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples M.D.				22. DATE SIGNED 7-7-67			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				6 Hanover Rd. Reisterstown, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF July 10, 67		23c NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d LOCATION (City or Town) (County) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons				ADDRESS Reisterstown, Md.		25a REC'D BY REGISTRAR DATE JUL 11 1967	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09202 CERTIFICATE OF DEATH 09202									
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME: 1001 Arran Road					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Towson, Maryland d. STREET ADDRESS 1001 Arran Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROBERT First HAROLD Middle HABERCAM Last			4. DATE OF DEATH Month July Day 23 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1906 Dec. 31, 1906		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank M. Habercam					14. MOTHER'S MAIDEN NAME Rose Cunningham				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 214-01-9663		17. INFORMANT: wife Betty Mae Habercam, 1001 Arran Rd., Balto Co			Address Md. 21212	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH Several 72 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 23, 1949 , to July 23, 1967 , that (I) (we) last saw the deceased alive on Jan 25 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Frederick J. Vollmer					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 24 1967		
22c. PHYSICIAN'S NAME (Type) FREDERICK J VOLLMER					22d. ADDRESS 6100 York Rd Balto Md 21212				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/26/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Balto. City, Md.		
24. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City					ADDRESS 21201		25a. REC'D BY REGISTRAR JUL 26 1967		25b. REGISTRAR'S SIGNATURE James J. Jones

09203

CERTIFICATE OF DEATH

09203

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>BALTE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>6 yrs 5 mo</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. STREET ADDRESS <u>629 Dumbarton AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AGED WOMENS & AGED MEN'S HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>E.</u> Last <u>HAILE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas J. HAILE</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth J. SLADE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218-18-1142</u>	
17. INFORMANT <u>Horis Sherman</u>		Address <u>Towson md 615 Chestnut ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>4 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C-U-A 4 yrs ago</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 14, 1961</u> to <u>July 17, 1967</u> , that (I) (we) lost saw the deceased alive on <u>July 17, 1967</u> , and that death occurred at <u>6 P. M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>July 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland E. DAY</u>		22d. ADDRESS <u>4-E-33rd ST Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Balt. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Wm Coats Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>20 York Rd Towson Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 20 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Upperco</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Upperco</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Carmel Rd.</u>						d. STREET ADDRESS <u>Mt. Carmel Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Erma</u> Middle <u>E.</u> Last <u>Hale</u>			4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 22, 1892</u>			9. AGE (In years last birthday) <u>75</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KING OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Parkton, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George W. Wisner</u>						14. MOTHER'S MAIDEN NAME <u>Mary E. Hale</u>					
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-34-7082</u>		17. INFORMANT <u>Doris V. Grumm, Upperco, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of U. Bladder & Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes; Hypertensive C-v. Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>7-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> , 19 <u>67</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Manuel C. Porterfield</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>7/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>						22d. ADDRESS <u>Hampstead, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Foreston Baptist</u>			23d. LOCATION (City, town or county) (State) <u>Upperco, Md.</u>		
24. FUNERAL DIRECTOR <u>Robert Hartman, New Freedom, Pa.</u>						25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G3,1 07/27/67 ph Items 8 & 9 Film G 392 8/29/67 iml
09205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09205

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY BALTO	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO Rural Overlea		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 West Elm		e STREET ADDRESS 21 West Elm	
3 NAME OF DECEASED (Type or print) MILDRED ELLEN HALL		4 DATE OF DEATH (Month Day Year) July 24 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-18-1921 9 AGE (In years last birthday) 46
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John P. Mc Donough		14 MOTHER'S MARDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) none		16 SOCIAL SECURITY NO	
17 INFORMANT Family records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot (12 gauge) DUE TO (b) Shot Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depression		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self-inflicted shotgun blast thru mouth	
20c TIME OF INJURY Month Day Year 2:30 pm 7-24 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory street off cabldg etc) Home		20f (City or town) (County) (State) BALTO Overlea Md	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Ayle		22. DATE SIGNED 7-24-67	
EXAMINER'S NAME (Type) JOHN C. Ayle		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) 7527 Belair Rd	
23a BURIAL CREMATION Burial	23b DATE THEREOF 7/25/67	23c NAME OF CEMETERY OR CREMATORY Satys Cemetery	23d LOCATION (City Town) (County) (State) Lutherville Md.
24 FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson Md.	
25 REC'D BY REG'STRAR JUL 31 1967		26 REG'STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09206

CERTIFICATE OF DEATH

09206

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. med Center</u>				d. STREET ADDRESS <u>Hillcrest Ave.</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harry Smokey Hammond</u>				4. DATE OF DEATH Month Day Year <u>7 9 1967</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-1886</u>	
9 AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		13 FATHER'S NAME <u>Clinton Hammond</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>219-36-0922</u>		17 INFORMANT <u>PT's chart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>Arterio-sclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Benign prostatic hypertrophy - urinary retention - ? Ca prostate.</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6/9</u> , 19 <u>67</u> , to <u>7/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> , 19 <u>67</u> , and that death occurred at <u>7:00 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>Derek A. Bruce</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>				22d. ADDRESS <u>G. B. M.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulme Valley Mem. Gdns</u>		23d. LOCATION (City or Town) (County) (State) <u>Timonium Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>				ADDRESS <u>New Freedom Pa.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09207

CERTIFICATE OF DEATH

09207

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY in lb <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Gus</u> Last <u>Harman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. CO. OR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01 10-17-02</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown - Decorator</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State or foreign country) <u>Ellicott City Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>James Harman</u>		15. MOTHER'S M.A.DEN NAME <u>unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		17. SOCIAL SECURITY NO. <u>218-14-5598</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
4 (and trans. if any, which gave rise to immediate cause (a), stating the underlying cause last)		<u>Myocardial Infarction</u> <u>Atherosclerotic Heart disease</u> <u>Rheumatic heart disease - Mitral Regurg.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> , 19 <u>67</u> , to <u>July 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 21</u> , 19 <u>67</u> , and that death occurred at <u>1:40 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>7-25-67</u>	<u>Lakeview Memorial Cemetery</u>	<u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Elsworth Armacost - 4600 Liberty Heights Ave.</u>		25a. RECEIVED BY REG. STAMP <u>JUL 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

09208

CERTIFICATE OF DEATH

09208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT NURSING HOME</u> <u>FREDERICK AVE</u>		d. STREET ADDRESS <u>6215 JOHNNYCAKE RD.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOE HENRY HARRELL</u>		4 DATE OF DEATH Month Day Year <u>7 11 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/81</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ROCKINGHAM County, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY HARRELL</u>		14. MOTHER'S MAIDEN NAME <u>ELLA BAYNES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>239-18-5872A</u>	
17. INFORMANT <u>J. W. HARRELL</u>		Address <u>ELLICOTT CITY, MD</u> <u>42 DEERFIELD DRIVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPIRATION & ASPHYSIATION</u> DUE TO (b) <u>INANITION & RT. HEMIPARESIS</u> DUE TO (c) <u>CEREBRAL THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u> <u>26 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 JUNE, 1967</u> to <u>11 JUL, 1967</u> , that (I) (we) last saw the deceased alive on <u>6 JUL 1967</u> , and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Irwin H. Moss, MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>IRWIN H. MOSS, MD</u>		22d. ADDRESS <u>5836 WESTVIEW MALL, BALTO, MD 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GUILDFORD MEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>GREENSBORO, N.C.</u>	
24. FUNERAL DIRECTOR <u>E.S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>UL 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>HANES LINEBURN F.H.</u>			

CERTIFICATE OF DEATH

09209

09209

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN b 4 years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		d. STREET ADDRESS 115 Algate Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mr. Christopher		First		Middle Hempel		Last		4. DATE OF DEATH July 23 1967		Month		Day		Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1883		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed				10b. KIND OF BUSINESS OR INDUSTRY Home furnishing Store				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Hempel						14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 218-28-4136						17. INFORMANT Mrs. William Chew Owings Mills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) A.S.C.V.D.																	
Conditions, if any, which gave rise to immediate cause (b) (Released by Dr. Caples per phone.)																	
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																	
Cachexia																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19																	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work																	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)																	
20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from 23 July 67 , 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.																	
22a. SIGNATURE Charles H. Williams, M.D.																	
22b. DATE SIGNED																	
22c. PHYSICIAN'S NAME (Type) Charles H. Williams, M.D.																	
22d. ADDRESS 1632 Reisterstown Rd.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial																	
23b. DATE THEREOF 7/26/67																	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery																	
23d. LOCATION (City, town or county) (State) Pikesville, Maryland																	
24. FUNERAL DIRECTOR'S SIGNATURE H. J. Schmitt																	
ADDRESS Owings Mills, Md.																	
25a. REC'D BY REGISTRAR JUL 26 1967																	
25b. REGISTRAR'S SIGNATURE Charles J. J...																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NEW YORK AND STATE DEPARTMENT

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY in 1b 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. Co. General		e. STREET ADDRESS 3414 Mayfair Rd.	
3 NAME OF DECEASED (Type or print) CARRIE A. HERBOLD		4. DATE OF DEATH Month 7 Day 4 Year 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-8-'80
9 AGE (In years last birthday) 87 yrs.		10 IF UNDER 1 YEAR Months Days Hours Mins	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Balto.		12 CITIZEN OF WHAT COUNTRY? W.S.A.	
13 FATHER'S NAME CONRAD SCHUMANN		14 MOTHER'S MAIDEN NAME Mary SCHMIDT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17 INFORMANT Wm Edw. Herbold (Same)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Probable Myocardial Infarction DUE TO (c) or Acute Cardiac Arrhythmia		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured L. hip June 8, 1967 nailed 2-11-67		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTE <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Patient fell at home	
20c TIME OF INJURY Month, Day, Year Hour 2 p.m. 6-8-1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) Balto. (County) (State) Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. CAPLES, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 7-5-67			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 7-7-67	
23c NAME OF CEMETERY OR CREMATORY London Park Cemetery		23d LOCATION (City or Town) BALTIMORE, Md (County) (State)	
24. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hgts.		25a DEC'D BY REGISTRAR JUL 7 1967 25b REGISTRAR'S SIGNATURE J. Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09211

09211

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 606 Baltimore Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last TIMOTHY HERDL				4. DATE OF DEATH Month Day Year July 26 19 67			
5. SEX Male		6. CO. OR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/67	
9. AGE (In years last birthday) 6 Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Herdl				14. MOTHER'S MAIDEN NAME ANNE CONFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16. SOCIAL SECURITY NO none		17. INFORMANT Family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden unexpected death in infancy DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 8)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				22. DATE SIGNED July 26, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/28/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Maria		23d. LOCATION (City or town) (County) (State) Towson Md.	
24. FUNERAL DIRECTOR John Burns Sons				25a. REC'D BY REGISTRAR 610 York Rd.			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09212

CERTIFICATE OF DEATH

09212

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>108 Chestnut Hill Lane</u>		d. STREET ADDRESS <u>108 Chestnut Hill Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Edward</u> Last <u>Hewes</u>		4 DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 3, 1900</u>
9 AGE (In years) <u>67</u> yrs		10 IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Vice President Union Trust Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Md.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles K. Hewes</u>		14 MOTHER'S MAIDEN NAME <u>Mary Brandenburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>218-03-1990</u>	
17 INFORMANT <u>Mrs. Estelle S. Hewes</u>		Address <u>Reisterstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2</u> DUE TO <u>2</u> (c) <u>2</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Interval</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-59</u> to <u>7-20-67</u> , that (I) <u>was</u> last saw the deceased alive on <u>7-2-67</u> and that death occurred at <u>6:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell</u> M.D.		22b. DATE SIGNED <u>7-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Reisterstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>July 22, 67</u>	<u>David Ridge Cemetery</u>	<u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 21 1967</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09213

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09213

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>BAH. County Gen. Hosp.</u>		d. STREET ADDRESS <u>Dogwood Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>JOHN F. Hickey</u>		4 DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/24/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodlawn Cemetery</u>	11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
13 FATHER'S NAME <u>JOHN Hickey</u>		14. MOTHER'S MAIDEN NAME <u>LAURA COLSON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>215-24-124</u>	17 INFORMANT <u>Mrs. Mary Hickey</u> Address <u>Dogwood Rd Baltimore MD</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple peripheral pulmonary emboli - pulmonary infarcts</u> INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (b) <u>Thrombosis of periprostatic & pelvic veins</u> ?			
DUE TO (c) <u>Primary Carcinoma of lung with metastasis</u> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>67</u> , to <u>7-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-15</u> , 19 <u>67</u> , and that death occurred at <u>1:02 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>D. Simon</u>		22b. DATE SIGNED <u>7-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. SIMON</u>		22d. ADDRESS <u>Balti Co. Gen Hosp. Randallstown MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Alphonsus Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodstock Baltimore MD</u>
24. FUNERAL DIRECTOR <u>Foring Byers 8728 Liberty Rd</u>		25a. REC'D BY REGISTRAR <u>md</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
		DATE <u>JUL 18 1967</u>	

09214

CERTIFICATE OF DEATH

09214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY in lb 1 wk. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton #21120 d. STREET ADDRESS Jordan Saw Mill Rd. Parkton, Maryland #21120 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Bisker Randolph Hollingshead				4 DATE OF DEATH July 10 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1920	
9. AGE (In years last birthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY Penna. Railroad		11. BIRTHPLACE (County & State, or foreign country) Whitehall, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bisker Hollingshead				14. MOTHER'S MAIDEN NAME Viola ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 166-16-9311		17. INFORMANT Mrs. Mabel Hollingshead	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory acidosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypoventilation. (c) Obesity.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 3, 1967 , to July 10, 1967 , that (I) (we) last saw the deceased alive on July 10 19 67 , and that death occurred at 6:35 AM from causes and on the date stated above.							
22a. SIGNATURE M. S. Cockburn				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) M. S. Cockburn, M.D.				22d. ADDRESS 7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 1967		23c. NAME OF CEMETERY OR CREMATORY West Liberty Cemetery		23d. LOCATION (City or town) (County) (State) White Hall, Md.	
24. FUNERAL DIRECTOR Joseph Hartenstein, New Freedom, Pa.				25a. RECEIVED BY REGISTRAR JUL 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

C9215

C9215

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>1 MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 Hastings Ave.</u>				d. STREET ADDRESS <u>1922 WILKENS AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WILLIAM Howard Honeycutt</u>				4 DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1967</u>			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Nov. 24, 1908</u>	
9 AGE (In years last birthday) <u>58</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UTILITY Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TENNESSEE</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CALVIN Honeycutt</u>			
14. MOTHER'S MAIDEN NAME <u>SALLY TERRY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>			
16. SOCIAL SECURITY NO <u>409-09-5695</u>				17. INFORMANT <u>ETHEL Honeycutt</u> Address <u>1922 Wilkens Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVA. BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>530</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-23-</u> , 1967, to <u>7-29-</u> , 1967, that (I) (we) last saw the deceased alive on <u>7-28</u> , 1967, and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				22b. DATE SIGNED <u>7-31-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>	
22d. ADDRESS <u>6209 Frederick Ave - Baltimore - 28, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>Geo. L. Schwab Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>Francis W. Miller 2101 Frederick Ave.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

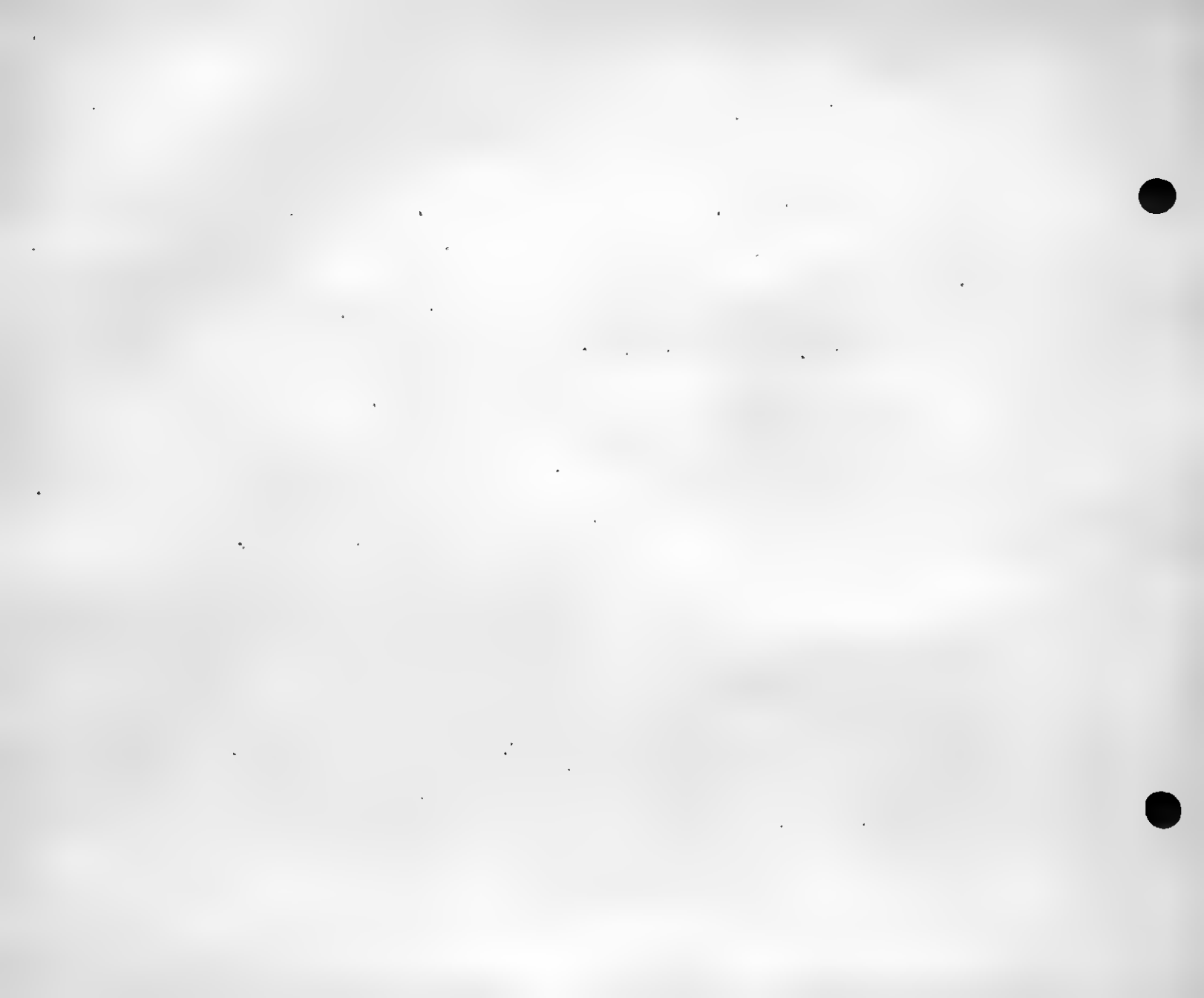
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09216											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN ID <i>3 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i> 03-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Dulaney-Towson Nursing Home</i>						d. STREET ADDRESS <i>638 W. Chesapeake Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Adam</i> Last <i>Horn</i>			4. DATE OF DEATH Month <i>July</i> Day <i>6</i> Year <i>1967</i>								
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>January 15, 1975</i>		9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stonemason-ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Henry G. Horn</i>						14. MOTHER'S MAIDEN NAME <i>Annice C. Ubitz</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>216-12-5078A</i>		17. INFORMANT <i>Family records</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4201 DUE TO (b) <i>Atrial fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 5, 1967</i> to <i>July 6, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 5, 1967</i> , and that death occurred at <i>12:10 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Charles H. Klein</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6 July 67</i>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>July 10, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Old Salem Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Jarrettsville, Harford Co., Md.</i>		
24. FUNERAL DIRECTOR <i>Horn & Sons, Towson, Maryland</i>						25a. REC'D BY REGISTRAR DATE <i>JUL 11 1967</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) TOWSON		c LENGTH OF STAY IN ID PASADENA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BENDIX RADIO CORP.		d STREET ADDRESS 57 Poplar Ridge Rd. Box 288A	
3 NAME OF DECEASED (Type or print) First CORBIN Middle J Last HOUCK		4 DATE OF DEATH Month July Day 12 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED W DOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years lost birthday) 50 yrs
9 UNDER 1 YEAR Months 12 Days 19 Hours 67		10 IF UNDER 24 HRS Months 12 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sander		10b KIND OF BUSINESS OR INDUSTRY Sheet Metal	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Milton Houck		14 MOTHER'S MAIDEN NAME Mary Sanks	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-16-8654	
17 INFORMANT Mrs. Jeanne Mills (daughter)		Address Same As #2	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Occlusion Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
Burial	July 15, 1967	Glen Haven Memorial	Glen Burnie, Md.
24. FUNERAL DIRECTOR R.V. Singleton	ADDRESS Singleton Funeral Home		25a. REC'D BY REG. STRAR JUL 13 1967
		25b. REG. STRAR'S SIGNATURE Charles J. Jager	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09218

CERTIFICATE OF DEATH

09218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and informant within 72 hours after death.

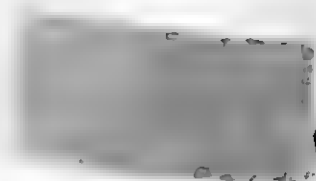
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria Rest Home</u>		d. STREET ADDRESS <u>Glenarm Rd. Glenarm</u>	
3. NAME OF DECEASED (Type or print) <u>Sister M. Pietra Huc Kestien</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>73</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Pittsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Peter Huc Kestien</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Reismann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>218-54-1328-I1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Brach adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>67</u> , to <u>7-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-10</u> 19 <u>67</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry L. McCorkle</u>		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY L. MCCORKLE MD</u>		22d. ADDRESS <u>Phoenix Maryland 21131</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Arm, Maryland</u>
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u> ADDRESS <u>817 Scarlett Dr. Towson, Maryland 21204</u>		25a. REC'D BY REGISTRAR <u>J. Charles Yunge</u> 25b. REGISTRAR'S SIGNATURE <u></u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, print the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. The funeral director should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div>Item 20 Film 390 7-13-67</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>09218</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>09218</div>											
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Town				c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						d. STREET ADDRESS 4806 Liberty Heights Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Gertrude H Hughes						4. DATE OF DEATH Month 7 Day 5 Year 19 67					
5 SEX F		6 COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/03		9 AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Education		11 BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry Fenzel						14. MOTHER'S MAIDEN NAME Elizabeth Kreigenhofer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				6 SOCIAL SECURITY NO. 214-40-4560		17 INFORMANT Mrs. Wm. D. Ruff-Baltimore, Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY Crushing injury to chest IMMEDIATE CAUSE (a) Crushing injury to chest DUE TO (b) Crushing injury to chest DUE TO (c) Crushing injury to chest											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Standing behind auto that moved backward and ran over her.											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Standing behind auto that moved backward and ran over her.							
20c. TIME OF INJURY Month, Day Year July 5 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Parking lot		20f. (City or town) (County) (State) Balto. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.						22. DATE SIGNED 7/7/67					
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.						Address (Street, city, town or county) Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 10 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer				23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Harry H. Armbrust						Address 4204 Ridgewood Ave. Baltimore, Md.		25a. RECO BY REGISTRAR JUL 10 1967		25b. REGISTRAR'S SIGNATURE Charles F. O'Donnell	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event with 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09220

09220

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if inst'l on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN lb Essex years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2100 Tred-Avon Rd.		d. STREET ADDRESS 2100 Tred-Avon Rd.	
3. NAME OF DECEASED (Type or print) Agnes Victoria Hunter		4. DATE OF DEATH Month July Day 2 Year 1967	
5. SEX Female	6. CO. OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1895
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Table Operator	
10b. KIND OF BUSINESS OR INDUSTRY Glen L. Martin		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William D. K. Lee	
14. MOTHER'S MAIDEN NAME Mary Larrimore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-26-3799		17. INFORMANT Address Mrs. Elizabeth A. Sternberg, Balto. 29, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 4201 Acute Coronary Occlusion HCUD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 pm	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C. Patterson M.D.		22. DATE SIGNED 7/2/67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 5, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cem	23d. LOCATION (City or town) (County) (State) Annapolis, Anne Arundel, Md
24. FUNERAL DIRECTOR Charles F. Bell, Jr.		25. REC'D BY REGISTRAR Charles Judge	
Address Charles F. Bell, Jr. 172 West St. Annapolis, Md		DATE JUL 6 1967	

09221

09221

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 118 Fairfield Drive		d. STREET ADDRESS 118 Fairfield Drive	
3 NAME OF DECEASED (Type or print) First Middle Last William P. Ihrie		4 DATE OF DEATH Month Day Year July 13 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1884
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ihrie		14. MOTHER'S MAIDEN NAME Edith Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-8102	
17. INFORMANT Paul D. Ihrie, 5902 Roland Ave. 21210		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 7 days 20 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1957 to July 13, 1967 , that (I) (we) last saw the deceased alive on July 13, 1967 , and that death occurred at 5 H M, from causes and on the date stated above.			
22a. SIGNATURE James E. Rowe		22b. DATE SIGNED 7/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. James Rowe		22d. ADDRESS 5550 Baltimore National Pike	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-15-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09222

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Sam Will Avenue		e. STREET ADDRESS 19 Sam Will Avenue	
3. NAME OF DECEASED (Type or print) EDWIN LEE IRETON		4. DATE OF DEATH Month July Day 28 Year 1967	
5. SEX Male	6. CO. OR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1910 AGE (in years last birthday) 57 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Black and Decker		10b. KIND OF BUSINESS OR INDUSTRY Tool Maker	
11. BIRTHPLACE (State or foreign country) Webb, Dewey Co. Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winfield Scott Ireton		14. MOTHER'S MAIDEN NAME Alvira Frances Shaner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 567-07-2708	
17. INFORMANT Mrs. Violet M. Ireton,		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		22. DATE SIGNED 7/28/67	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		Address (Street, city, town, or county)	
23a. BURIAL (CREMATION REMOVAL) (Specify) Burial	23b. DATE THEREOF July 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 1mth 5dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 3501 Toledo Terrace	
3. NAME OF DECEASED (Type or print) First John Middle S. Last Jackson		4. DATE OF DEATH Month July Day 14 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) warehouse manager		10b. KIND OF BUSINESS OR INDUSTRY freight	9. AGE (In years lost birth day) 60 yrs
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Emma Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from June 7, 1967 to July 14, 1967 , that he (we) last saw the deceased alive on July 14, 1967 , and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Vicente M. Ruco		22b. DATE SIGNED 7-15-67	
22c. PHYSICIAN'S NAME (Type) VICENTE M RUO		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Catonsville Prince Geo. Co. Md.
24. FUNERAL DIRECTOR J. Arthur Dallas		25a. REC'D BY REGISTRAR 254 Carroll St. W. 4th fl.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUL 17 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21224	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 405 S. Robinson St.	
3 NAME OF DECEASED (Type or print) DANIEL J. JACOBS, Sr.		4. DATE OF DEATH Month July Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired American Smelting & Refining		9. AGE (In years lost birthday) yrs. 75	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Jacobs		14. MOTHER'S MAIDEN NAME Margaret J. Wagner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-10-3745	
17. INFORMANT Mrs. Estelle Jacobs wife, above		Address _____	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 1992 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from June 30, 1967 , to July 14, 1967 , that he (we) lost saw the deceased alive on July 14, 1967 , and that death occurred at 6:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Joel V. Tolentino		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) Joel V. Tolentino, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/67	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR JUL 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

39225

00225

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GANNISON MD.</u>				c. LENGTH OF STAY IN 1b <u>144</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>For E. G. Nursing Home</u>				e. STREET ADDRESS <u>2912 Hilldale Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>JACOBS</u> Last <u>JACOBS</u>				4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>[REDACTED]</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher + Simon + Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A. Baltimore, Maryland, S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis Simon</u>				14. MOTHER'S MAIDEN NAME <u>Lenora Singer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-56-1804</u>			
17. INFORMANT <u>Mrs. Joanne Solomon, Great Neck, L.I.N.Y.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>unknown</u> <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> , to <u>7-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-1</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>David I. Miller M.D.</u>							22b. DATE SIGNED <u>7-2-67</u>
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>							22d. ADDRESS <u>Linson Rd. Owings Mills, Md</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 4, 1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Anino</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. 6010 Reisterstown Road</u>							25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN b. <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md.</u> d. STREET ADDRESS <u>2303 Springlake Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace Virginia Johnson</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Cau.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-29-19</u> 9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1967</u> 13. FATHER'S NAME <u>James Finno</u> 14. MOTHER'S MAIDEN NAME <u>Lillian Dondero</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>103-07-2633</u> 17. INFORMANT <u>J. Fred Johnson</u> Address <u>same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Breast (carcinoma)</u> DUE TO (b) <u>metastasis (multiple)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>13 days 2 months</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>July 3</u> 19<u>67</u>, and that death occurred at <u>8:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>July 3 1967</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. A. MONTAGUE</u> 22d. ADDRESS <u>MEDICAL ARTS BUILDING</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 7, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u> 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towne</u> ADDRESS <u>1040 York Rd. 21204</u> 25a. REC'D BY REGISTRAR <u>JUL 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



09227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09227

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4117 Klauseman Rd		e. STREET ADDRESS 4117 Klauseman	
3 NAME OF DECEASED (Type or print) Mabel Elizabeth Johnson		4 DATE OF DEATH Month July Day 10 Year 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 27 July 1897
9 AGE (in years, months, and days) 69 yrs		10 UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Frank King		14 MOTHER'S MAIDEN NAME Annie Dean	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT Mr. Lawrence G. Johnson		Address same address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 7221 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Chronic Bronchitis, Peptic ulcer		INTERVAL BETWEEN ONSET AND DEATH 10	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		22. DATE SIGNED 7-10-67	
EXAMINER'S NAME (Type) JOHN C. Hyle		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7/14/1967	23c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Wm. J. Tuckner Sons		25a. REC'D BY REGISTRAR JUL 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

99226

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 53 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ARTHUR Middle WILLIAM Last JONES		4 DATE OF DEATH Month July Day 1 Year 19 67	
5 SEX Male		6 COLOR OR RACE Negro	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1916	
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months 50 Days 1 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11 BIRTHPLACE (County & State, or foreign country) Westover, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Jones		14. MOTHER'S MAIDEN NAME Elizabeth Collier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 214 18 44 19	
17 INFORMANT Clinical Reds VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE WITH UREMIA (c) BENIGN PROSTATIC HYPERTROPHY		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 9 , 19 67 , to July 1 , 19 67 that (X) (we) last saw the deceased alive on July 1 , 19 67 , and that death occurred at 4:45 M., from causes and on the date stated above.		22a. SIGNATURE Peter V. Juvan M.D. 22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Baptist Church		23d. LOCATION (City or Town) (County) (State) Princess Anne Maryland	
24. FUNERAL DIRECTOR William H. James Jr.		25a. REC'D BY REGISTRAR Princess Anne, Maryland DATE JUL 7 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Juvan			

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 26 dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt, Maryland d. STREET ADDRESS 410 Riggs Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Jones						4. DATE OF DEATH Month July Day 10 Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-2-78		9. AGE (In years last birthday) 91 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Cornelius Jones						14. MOTHER'S MAIDEN NAME Mary E Gates					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 579-20-6477		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction HAI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Heart Dis. 20yrs. DUE TO (c) Arteriosclerosis, generalized, senile 20yrs.										INTERVAL BETWEEN ONSET AND DEATH acute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, generalized, organism undetermined.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that no (this hospital) attended the deceased from June 14, 1967 , to July 10, 1967 , that we (we) last saw the deceased alive on July 10, 1967 , and that death occurred at p. M, from the causes and on the date stated above.											
22a. SIGNATURE Anthony J. Young, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-11-67			
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St Josephs catholic				23d. LOCATION (City, town or county) (State) Amundale Pro Geo Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons						ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09236

CERTIFICATE OF DEATH

09237

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			c. LENGTH OF STAY IN 1b <u>7</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 169 Beaver Dam Road</u>						d. STREET ADDRESS <u>Box 169 Beaver Dam Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>Alfred Monroe</u>				4. DATE OF DEATH <u>July 3 1967</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 27, 1906</u>		9. AGE (In years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS Hours <u>3</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof-Reader</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John A. Joslin</u>						14. MOTHER'S MAIDEN NAME <u>Lillian Kirby</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-03-7279</u>		17. INFORMANT <u>Mrs. Mabel Joslin</u> Address <u>Same as 2</u>							
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Immediate Years -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.													
22a. SIGNATURE <u>Robert W. Edmonds</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 6, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Edmonds</u>						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>July 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem'l. Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Parkville, Balt. Maryland</u>					
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson</u> ADDRESS <u>1050 York Road Towson, Maryland</u>						25a. REG'D BY REGISTRAR DATE <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09231

CERTIFICATE OF DEATH

09231

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1123 Granville Rd. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1123 Granville Rd.			2. USUAL RESIDENCE (Where deceased lived, if inst. in an. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1123 Granville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Beatrice B. Judy			4. DATE OF DEATH Month July Day 8 Year 1967		
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/20	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bullock			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Charles Judy 1123 Granville Rd. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATIC HEART DISEASE DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 3 YRS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)			
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov 11 , 1958, to July 8 , 1967, that (I) (we) last saw the deceased alive on June 29 , 1967, and that death occurred at 5A M. from causes and on the date stated above.					
22a. SIGNATURE Kennard Yaffe		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 7/10/67		
22c. PHYSICIAN'S NAME (Type) Kennard Yaffe, M. D.		22d. ADDRESS 5501 Forest Park Av.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/11/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE JUL 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judy	

09232

CERTIFICATE OF DEATH

09232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pikesville Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore General Hosp.</u>		d. STREET ADDRESS <u>6 Orchard Bl. 21208</u>	
3. NAME OF DECEASED (Type or print) <u>ISAIAH CHARLES KAUFFMAN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1902</u>
9. AGE (in years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ATP</u>	
11. BIRTHPLACE (County & State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Kauffman</u>		14. MOTHER'S MAIDEN NAME <u>Blizard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-4572</u>	
17. INFORMANT <u>Alfred Kauffman</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cong. Heart Failure, A.S.C.V.D.</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>2</u> <u>1 YR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NEPHROLITHIASIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 1951</u> , to <u>July</u> , 1967, that (I) (we) last saw the deceased alive on <u>2 July</u> , 1967, and that death occurred at <u>8:38 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles V. Williams</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles V. Williams, MD</u>		22d. ADDRESS <u>Pikesville 21208, Md.</u>	
23a. BURIAL, CREMATION, or MOVING (Specify)	23b. DATE THEREOF <u>July 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Park, Pikesville, Md.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>Howell Funeral Home, Pikesville, Md.</u>		25a. FILED BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

09233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

09233

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3020 Wallford Drive		e STREET ADDRESS 3020 Wallford Drive f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Keith Last Keith		4 DATE OF DEATH Month July Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/28/16
9 AGE (In years last birthday) 51 yrs		10 UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Electrician - Retired		10b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Virginia	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME William Keith		14 MOTHER'S MAIDEN NAME Shelby Rhodes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 228-18-5750	
17 INFORMANT Mrs. Martha Keith, 3020 Wallford Dr.		Address Dundalk, Md.	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer, Right Lung DUE TO (b) Metastasis DUE TO (c) Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis EXAMINER'S NAME (Type) M. D.		22. DATE SIGNED 7-8-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6800 Morningson Rd. Dundalk, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/10/67	23c NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR JUL 11 1967 DATE	
25b REGISTRAR'S SIGNATURE J. Charles			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09234

09234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

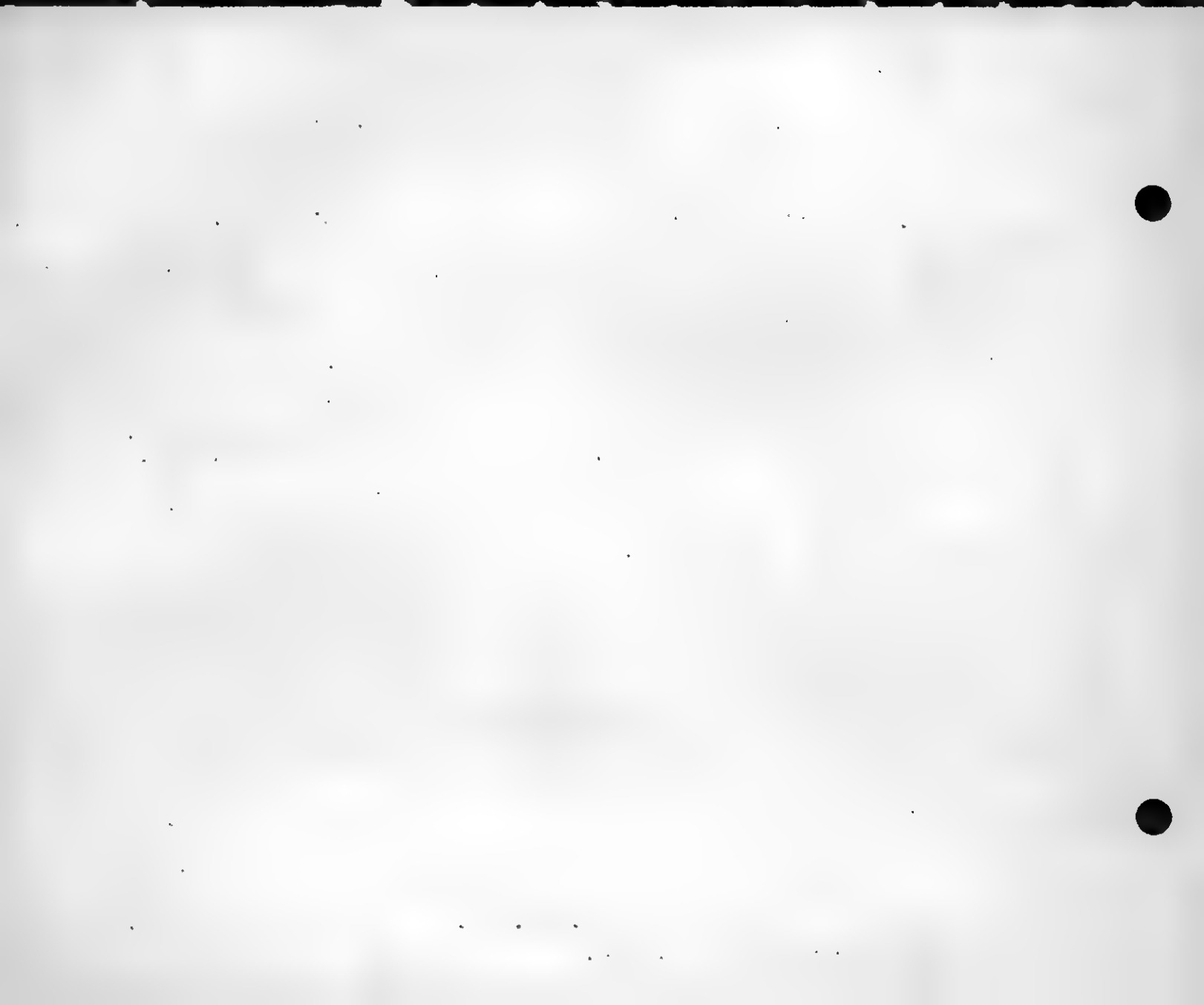
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c LENGTH OF STAY IN 1b <u>Baltimore 21204</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto Medical Center.</u>				d STREET ADDRESS <u>220 Maryland Ave</u>			
3 NAME OF DECEASED (Type or print) <u>Frank A. Louis Kelly</u>				4 DATE OF DEATH Month <u>7</u> - Day <u>16</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-27-96</u>		9 AGE (in years last birthday) <u>71</u> yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor Gas & Elec. Co.</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Edward Franklin Kelly</u>				14 MOTHER'S MAIDEN NAME <u>Mary Bangs</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW1</u>				16 SOCIAL SECURITY NO <u>212-05-4961</u>		17 INFORMANT <u>Patient's Chart.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pericarditis</u> DUE TO (b) <u>Wound infection after laryngectomy and esophagotomy</u> (c) <u>for carcinoma</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AS CVD</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour 'o m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>67</u> to <u>July 16</u> , 19 <u>67</u> that (we) last saw the deceased alive on <u>July 16</u> , 19 <u>67</u> and that death occurred at <u>4:00 AM</u> , from cause, and on the date stated above							
22a SIGNATURE <u>Kerffer J. Mitchell</u> M.D.				22b. DATE SIGNED <u>7-16-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Kerffer J. Mitchell</u>	
22d ADDRESS <u>G.B.M.C.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/19/67.</u>		23c NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 17 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1. and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
09235														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph's Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. 21234 b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1703 Aberdeen Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First John Middle Robert Last Kerns					4. DATE OF DEATH Month July Day 8 Year 19 67									
5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 5/20/97 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Supervisor (ret.)					10b. KIND OF BUSINESS OR INDUSTRY Army Airforce Exchange Va.					11. BIRTHPLACE (County & State, or foreign country) Va.				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME Harrison Kerns					14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes					16. SOCIAL SECURITY NO. 212-07-0834					17. INFORMANT 8240 Loch Raven Blvd. Lillian Creamer Kerns, wife,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture abdominal Aorta Aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Aorta Aneurysm DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on June 19 1967 , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE Rafael Hernandez					22b. DATE SIGNED 7-8-67									
22c. PHYSICIAN'S NAME (Type) Rafael Hernandez					22d. ADDRESS 8155 Loch Raven Bl.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 7/12/67					23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.				
23d. LOCATION (City, town or county) (State) Baltimore, Md.					24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane					25a. REC'D BY REGISTRAR JUL 11 1967				
25b. REGISTRAR'S SIGNATURE J. Channing														



MARYLAND STATE DEPARTMENT OF HEALTH

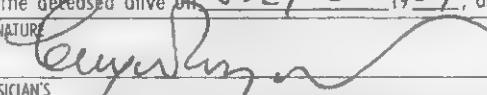
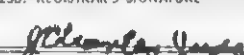
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09236

CERTIFICATE OF DEATH

09236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home				d. STREET ADDRESS 1249 Meridene Dr. 21212		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Catherine Last Killman				4. DATE OF DEATH Month July Day 2 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/1889		9. AGE (In years last birthday) yrs 78	10. IF UNDER 1 YEAR Months 2 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Paul				14. MOTHER'S MAIDEN NAME Caroline Wacker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-14-1296D		17. INFORMANT Mrs. Carolyn Correa		Address 1249 Meridene Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL COMA DUE TO CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ARTERIOSCLEROTIC VASCULAR DISEASE (b) 1 DAY (c) YEARS						INTERVAL BETWEEN ONSET AND DEATH HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECENT FRACTURE NECK OF FEMUR.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 2, 1967 to JULY 2, 1967 , that (I) (we) last saw the deceased alive on JULY 2, 1967 , and that death occurred at 5:50 P.M. from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) Enrique Moszkowski				22d. ADDRESS Caves & Hudson Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/67		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County Md.	
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road 21212				25a. REC'D BY REGISTRAR DATE JUL 5 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10655

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Bald</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>3004 Christopher Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Kingsbury</u> Last <u>Bald</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/86</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Geo Jefferies</u>		14. MOTHER'S MAIDEN NAME <u>Kate Whitehead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Coe</u>		Address <u>3004 Christopher</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> , 1967, to <u>July 30</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 30</u> , 1967, and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Adams</u>		22b. DATE SIGNED <u>July 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town or county) (State) <u>Balto</u>
24. FUNERAL DIRECTOR <u>W. Heemann</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1967</u>	
ADDRESS <u>6067 Harford Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

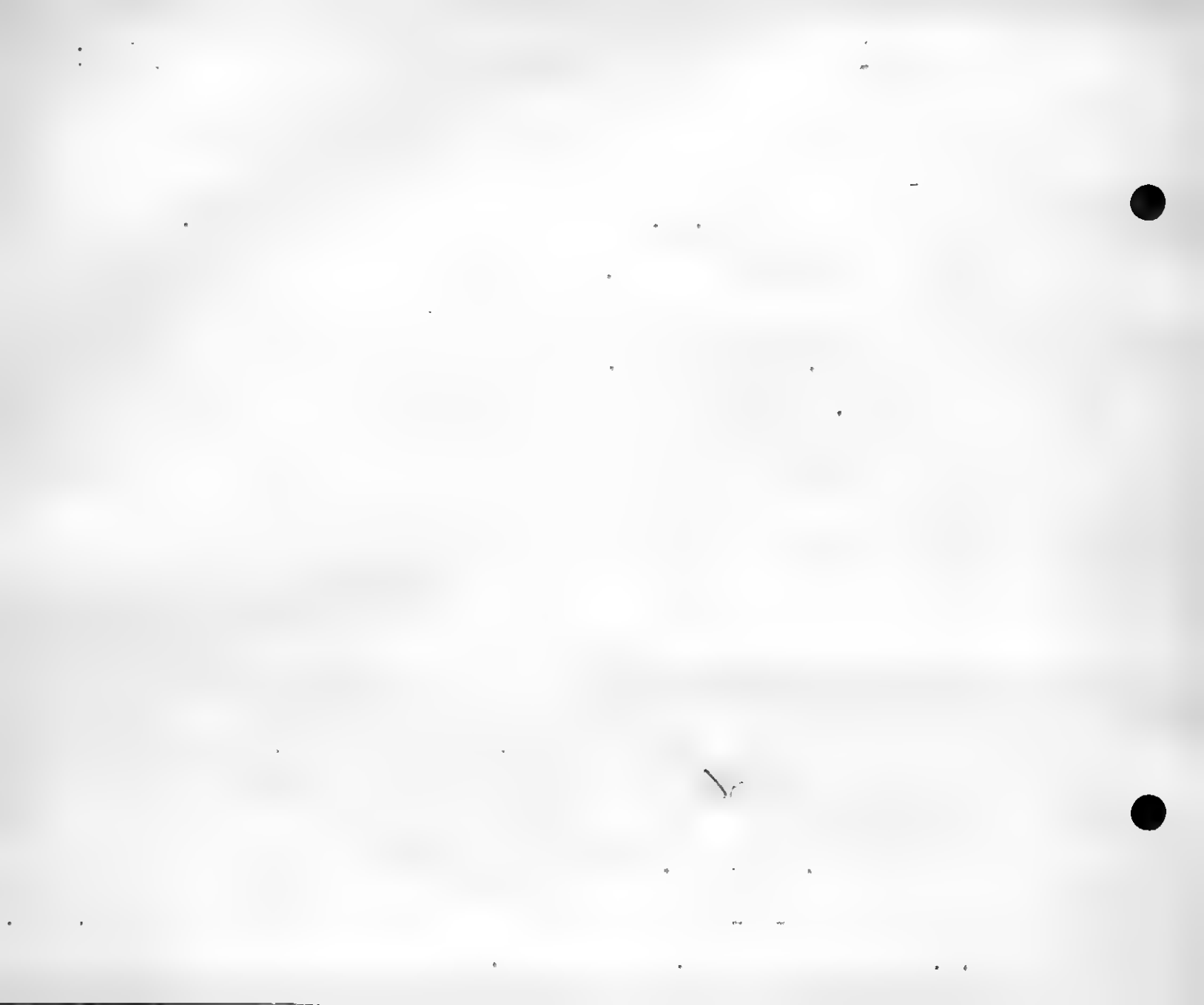
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09237

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney-Towson N. H.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William H. Kinnear		4. DATE OF DEATH Month Day Year July 21 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1895
9. AGE (In years last birthday) yrs. 71		10. F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Police Dept.		11b. KIND OF BUSINESS OR INDUSTRY Balto. City	
12. CITIZEN OF WHAT COUNTRY? Maryland (Balto. City) USA		13. FATHER'S NAME William M. Kinnear	
14. MOTHER'S MAIDEN NAME Florence Ohle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO 212-38-1257		17. INFORMANT William Henry Kinnear Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of liver. DUE TO Hepatic Cirrhosis with ascites (b) Hepatorenal Syndrome. DUE TO Acute heart failure and death (c) Acute heart failure and death		INTERVAL BETWEEN ONSET AND DEATH weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 27 June, 1967 to 22 July 19 67 , that (I) (we) lost the deceased alive on 22 July 19 67 and that death occurred at 9:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Joseph E. Muse Jr. M.D.		22b. DATE SIGNED 23 July 67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph E. Muse		22d. ADDRESS 2725 N. Charles St. Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-24-67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR JUL 24 1967	
ADDRESS 4905 York Rd., Balto.		25b. REGISTRAR'S SIGNATURE Richard Judge	



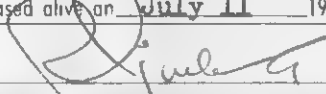

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09239		09239	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN TB Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21212 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 5509 The Alameda e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVELYN R. KIRCHHEINER		4. DATE OF DEATH Month July Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1901 9. AGE (In years lost birthday) 65 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Lamm	
14. MOTHER'S MAIDEN NAME Sarah McClain		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO --		17. INFORMANT Louis Kirchheiner Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive acute myocardial infarction DUE TO thrombosis of main right coronary artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 9, 1967 , to July 11, 1967 , that (I) (we) last saw the deceased alive on July 11, 1967 , and that death occurred at 8:10 PM , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 7/12/67	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela Gomez, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-15-67	23c. NAME OF CEMETERY OR CREMATORY Oaklawn	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.		25a. REC'D BY REGISTRAR DATE JUL 13 1967	25b. REGISTRAR'S SIGNATURE 



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09240

09233

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5646 Carville Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>5646 Carville Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Gertrude A. Kenny Klein</u> First Middle Last				4. DATE OF DEATH <u>July 4 1967</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1898</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
11a. BIRTHPLACE (County & State, or foreign country) <u>Balto City, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Thornton</u>				14. MOTHER'S MAIDEN NAME <u>Minna Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>215-01-2541</u>			
17. INFORMANT <u>Jack M. Manor (son)</u> Address <u>5646 Carville Ave.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Infarction</u> (c), stating the underlying cause last. <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)				20c. TIME OF INJURY Month, Day, Year <u>July 4, 1967</u> Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Baltimore</u> (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1964</u> to <u>July 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1967</u> , and that death occurred at <u>4:20 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Healey</u> M.D.				22b. DATE SIGNED <u>7/5/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John C. Healey</u>				22d. ADDRESS <u>Fairhope, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JULY 7-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walters Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Balto, Md.</u>				DATE <u>JUL 12 1967</u>			

MEDICAL CERTIFICATION

09241

CERTIFICATE OF DEATH

09240

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Wisconsin b. COUNTY Kenosha	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 2 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1811 Leadburne Rd. 21204		e. STREET ADDRESS 1814-75th. St.	
3 NAME OF DECEASED (Type or print) Charles A. Kopecki		4 DATE OF DEATH Month July Day 13 Year 1967	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (Country & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ahton		14. MOTHER'S MAIDEN NAME Novack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 390 03 5408	
17. INFORMANT Kopro		Address Richard Kopecki, 1811 Leadburne Rd. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Plural Effusion DUE TO Myocardial Degeneration		INTERVAL BETWEEN ONSET AND DEATH Sudden 5 Days 2 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/12/1967 to 2/13/1967 , that (I) (we) last saw the deceased alive on 2/12/1967 , and that death occurred at 3:40 M, from causes and on the date stated above.			
22a. SIGNATURE Charles T. O'Donnell		22b. DATE SIGNED 7/13/67	
22c. PHYSICIAN'S NAME (Type) Charles T. O'Donnell		22d. ADDRESS Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-67	
23c. NAME OF CEMETERY OR CREMATORY St. Georges		23d. LOCATION (City or Town) (County) (State) Kenosha, Wisconsin	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE JUL 14 1967	
		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

09242

09241

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm		d. STREET ADDRESS Manor Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amy Frances Kozak		4. DATE OF DEATH Month July Day 14 Year 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 8, 1897		9. AGE (In years) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY England		11. BIRTHPLACE (County & State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Francis Etherton		14. MOTHER'S MAIDEN NAME Theda ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Theodore Kozak 2803 Upbridge Ct. 21234		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June 29, 1967 to July 14, 1967 , that (I) (we) last saw the deceased alive on July 14, 1967 , and that death occurred at 11:40 PM from causes on and on the date stated above.		22a. SIGNATURE Joel Tolentino		22b. DATE SIGNED July 14, 1967		22c. PHYSICIAN'S NAME (Type) Joel Tolentino	
22d. ADDRESS 7620 York Rd., Towson, Md. 21204		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge		25c. REGISTRAR'S NAME John Charles Judge		25d. REGISTRAR'S ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

09247

09242

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN lb D.O.A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE COUNTY GEN HOSP.		d. STREET ADDRESS 2014 ENGEL WOOD AVE	
3. NAME OF DECEASED (Type or print) George Kraus		4. DATE OF DEATH 7/14/67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882
9. AGE (In years last b. day) 84 yrs		10. IF UNDER 1 YEAR 1967	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CITY, MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-01-7811-A	
17. INFORMANT NITA KRAUS (WIFE)		Address 2014 ENGEL WOOD, BALTIMORE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) generalized arteriosclerosis DUE TO (c) lost.			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 62 , to 7/8 , 19 67 , that (I) (we) last saw the deceased alive on 7/8 , 19 67 , and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Milton Schilowitz		22b. DATE SIGNED 7/15/67	
22c. PHYSICIAN'S NAME (Type) Milton Schilowitz, MD		22d. ADDRESS 64 Windsor Mill Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/17/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR J. I. Stansbury		25a. REC'D BY REGISTRAR JUL 17 1967	
ADDRESS 6411 Windsor Mill Rd.		25b. REGISTRAR'S SIGNATURE Charles Judge	

09244

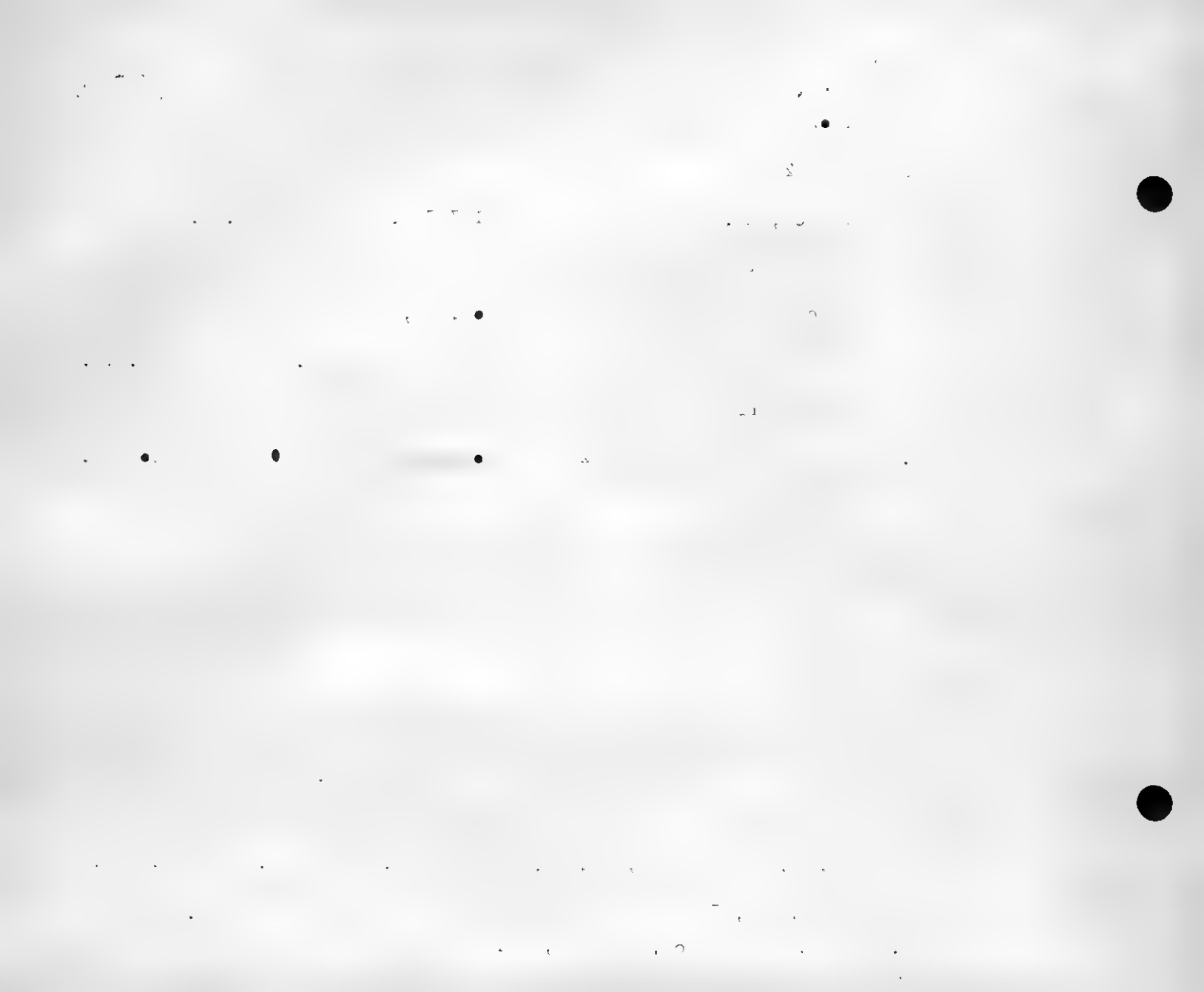
CERTIFICATE OF DEATH

09243

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Colorado b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21234		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denver	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8809 Littlewood, Rd.		d. STREET ADDRESS 13737 W. Virginia Ave. Dr.	
3 NAME OF DECEASED (Type or print) First Middle Last Julia Kerr Lambright		4 DATE OF DEATH Month Day Year July 2, 1967 19	
5 SEX F	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 11, 1896
9 AGE (In years last birthday) yrs. 70		10 IF UNDER 1 YEAR Months Days Hours Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Kerr		14. MOTHER'S MAIDEN NAME Julia Gass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 302 32 9203	
17. INFORMANT Dorothea Izant, 8809 Littlewood Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion - Instant DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis - right			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> #		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , to July 2, 1967 , that (I) was saw the deceased alive on June 25 19 67 , and that death occurred at 1 a. M, from causes and on the date stated above.			
22a. SIGNATURE W. H. Townshend		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) W. H. Townshend, Jr. M.D.		22d. ADDRESS 14 E. Eager St. - Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6, 67	
23c. NAME OF CEMETERY OR CREMATORY Beaver Cemetery		23d. LOCATION (City or Town) (County) (State) Beaver, Pa.	
24. FUNERAL DIRECTOR Will. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE JUL 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

09241

09241

1 PLACE OF DEATH a. COUNTY Balto. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 16 MONTHS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney-Towson Nursing Home			d. STREET ADDRESS 1401 MIDMEADOW RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Layman Last Layman			4. DATE OF DEATH Month July Day 22 Year 1967		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1881		9. AGE (In years last birthday) 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME Robert Harvey			14. MOTHER'S MAIDEN NAME Mary Gibson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-46-2830		17. INFORMANT MRS. MARY NORRIS, TOWSON, MD. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA DUE TO (b) CARCINOMA-COLON DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) A.S.C.V. DISEASE					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) this hospital attended the deceased from JAN. 19 66 , to JULY 23, 1967 , that (I) we last saw the deceased alive on JULY 23, 1967 , and that death occurred at 7:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Arthur Kargin		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) ARTHUR KARGIN M.D.	
22d. ADDRESS 1532 HAVENWOOD ROAD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 24, 1967		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	
23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.		24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. 21532			
25a. REC'D BY REGISTRAR DATE JUL 26 1967		25b. REGISTRAR'S SIGNATURE James J. Jones			

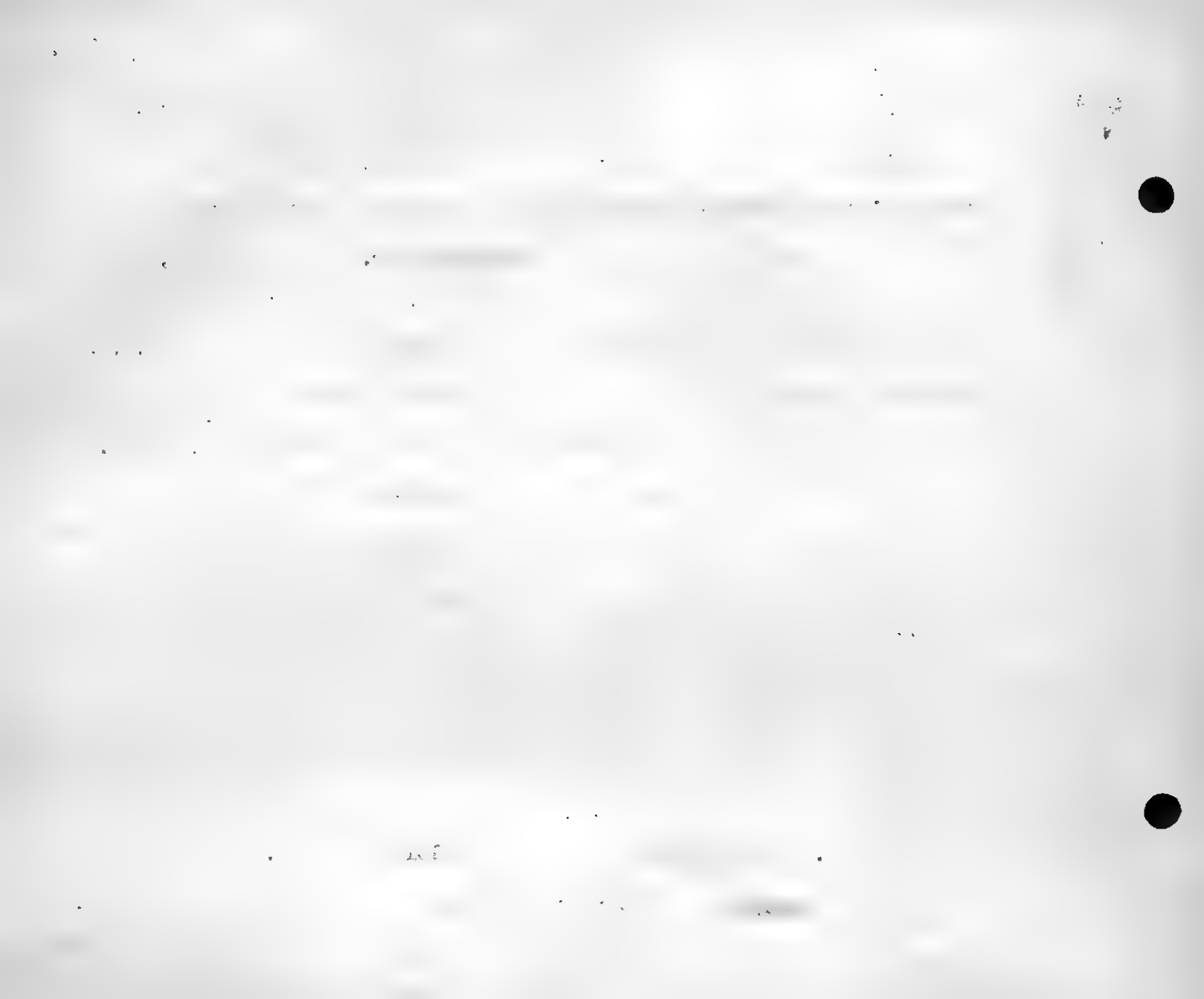
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armecost Nursing Home 812 Regester Ave					d. STREET ADDRESS 18 Dowling Circle Zone 18			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otto			First Middle Last Lengerhuis Sr.			4. DATE OF DEATH Month July Day 10 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1902		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop superintendant				10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gerhard Lengerhuis					14. MOTHER'S MAIDEN NAME Peterke Voermann				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 216 05 2885		17. INFORMANT Mrs Philiptine Lengerhuis Balto Md 21234			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases DUE TO Carcinoma of lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease								INTERVAL BETWEEN ONSET AND DEATH 6 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-20, 1969 to 7-10, 1967 that (I) (we) last saw the deceased alive on 7-9-1967 and that death occurred at 11:5 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. Alfred Ossman				22b. DATE SIGNED 7-11-67					
22c. PHYSICIAN'S NAME (Type) Dr. Alfred Ossman				22d. ADDRESS 1101 St Paul St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery			23d. LOCATION (City, town or county) (State) Woodlawn Md.		
24. FUNERAL DIRECTOR Loring Byers				ADDRESS 8728 Liberty Rd Randallstown Md		25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09247

CERTIFICATE OF DEATH

09246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 314 Ida Ave. Balto., 21221, Md.		e. STREET ADDRESS 314 Ida Ave., Balto., 21221, Md.	
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle HARRY Last LEONARD		4. DATE OF DEATH Month July Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1890
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Monumental Life	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Leonard		14. MOTHER'S MAIDEN NAME Theresa Peringer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-09-4095	
17. INFORMANT Andrew H. Leonard		Address 314 Ida Ave. Balto., 21, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension - cerebral - vascular - chronic - cerebral degeneration. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan - 1962 to 7/22 , 19 67 , that (I) (we) last saw the deceased alive on 7/20 , 19 67 , and that death occurred at 7:00 M. from causes on and on the date stated above.			
22a. SIGNATURE Joseph R. Liberto		22b. DATE SIGNED 7/25/67	
22c. PHYSICIAN'S NAME (Type) Joseph R. Liberto		22d. ADDRESS 3508 Bank St., Balto., 21224, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-67.	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (State) 4430 Belair Rd., Balto., Md.	
24. FUNERAL DIRECTOR Charles A. Zeiler		25a. REC'D BY REGISTRAR JUL 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09248

CERTIFICATE OF DEATH

09247

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 21061	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MEDICAL CENTER.		d. STREET ADDRESS Hamilton Place	
3. NAME OF DECEASED (Type or print) BABY GIRL LINSENMAYER		4. DATE OF DEATH Month 7 Day 27 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-67
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.		10b. KIND OF BUSINESS OR INDUSTRY N.A.	
11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GLENN ROSS LINSENMAYER		14. MOTHER'S MAIDEN NAME ANN LOUISE Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO N.A.	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. 776X IMMEDIATE CAUSE (a) Extremely premature with 284 gm weight DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/27, 1967 to 7/27, 1967 that (I) (we) last saw the deceased alive on 7/27, 1967 , and that death occurred at 5:01 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Adrian A. Hamrick M.D.		22b. DATE SIGNED 7/27/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	Aug. 1, 1967	GBMC	Towson Md. 21204
24. FUNERAL DIRECTOR John E. Adams, M.D. GBMC		25a. REC'D BY REGISTRAR AUG 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

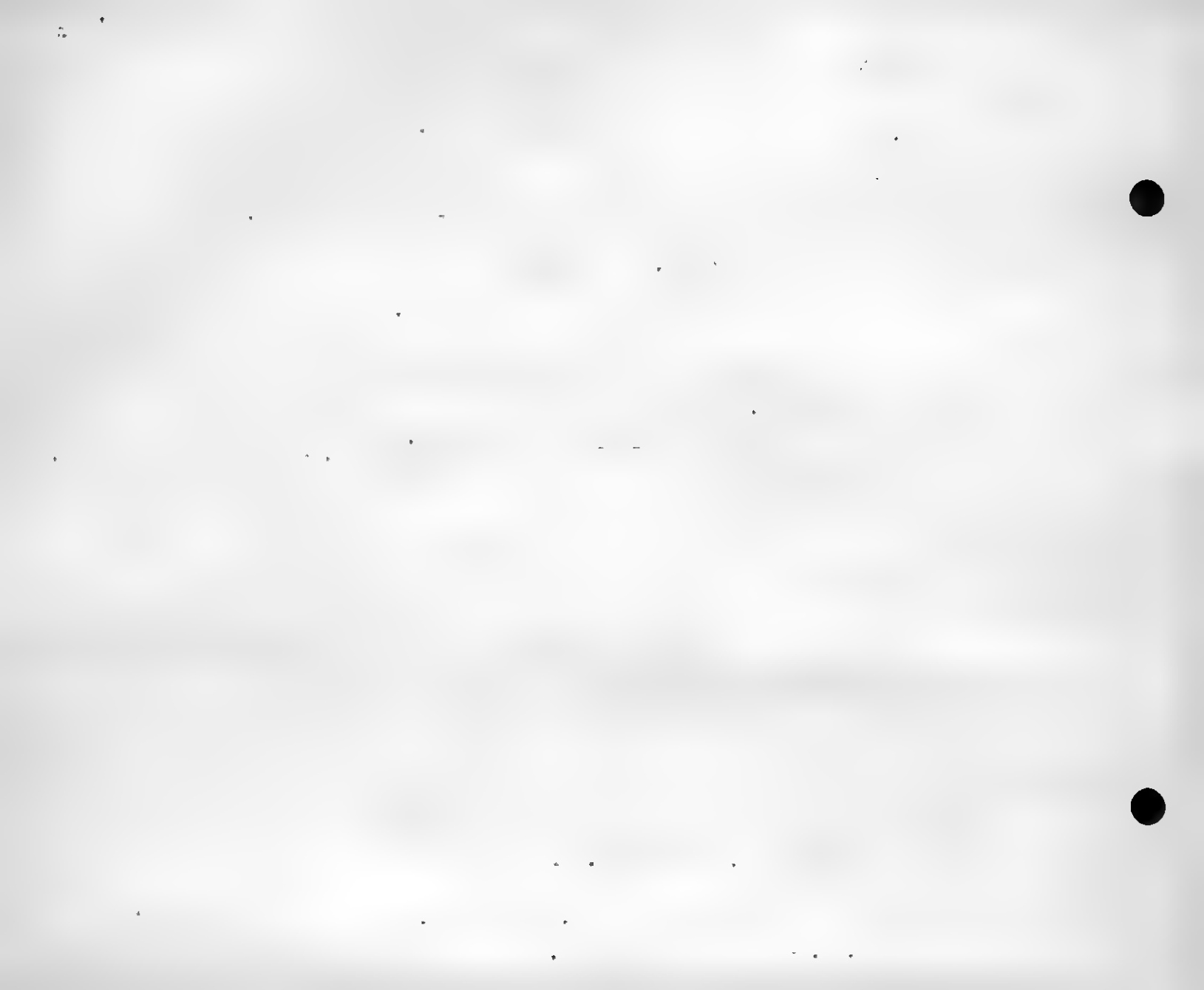
Item 2 Film 6397 7/21/67

09249

CERTIFICATE OF DEATH

09248

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bloomsbury Retreat				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore #29			
f. STREET ADDRESS 614 North Bend Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle G. Last Linthicum				4. DATE OF DEATH Month July Day 12 Year 19 67			
5. SEX M		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 4/83	
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Linthicum				14. MOTHER'S MAIDEN NAME Margaret Whitaker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO 216-05-8569		17. INFORMANT Helen L. Carter Address 954 Andrews Rd. -West Palm Beach, Fla.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4-1-1 IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 67 to 7/12 , 19 67 , that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at 7:30 P.M., from causes and on the date stated above							
22a. SIGNATURE Paul R. Ziegler				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/13/67	
22c. PHYSICIAN'S NAME (Type) Paul J. Ziegler, M. D.				22d. ADDRESS 200 WESTNOT HILL DR ELLICOTT CITY, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE: JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. Judge	



Item 2 Filed 8/21/67

09248

09250

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home		d. STREET ADDRESS 903-2A Nottingham Rd. Summitt Nursing Home 98, Smithwood Ave.	
3 NAME OF DECEASED (Type or print) Susan Frances Loechel		4 DATE OF DEATH Month July Day 19 Year 1967	
5 SEX F	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27/89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) yrs 78
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Beck		14. MOTHER'S MAIDEN NAME Frances	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Philip Loechel		Address 110 Donleigh Dr. - 21150	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral Vase Accident DUE TO (b) Hypertensive C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Deterioration of Bladder & Kidney			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 18, 1967 to July 19, 1967 that (I) (we) lost saw the deceased alive on July 18, 1967 and that death occurred at 7:00 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Thomas G. Abbott		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas Abbott		22d. ADDRESS 4509 Liberty Heights Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/21/67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE JUL 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09251

CERTIFICATE OF DEATH

09250

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON -4		c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21214	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER			d. STREET ADDRESS 5510 P. 19th ROAD		
3. NAME OF DECEASED (Type or print) First FRANK Middle William Last Loeschke			4. DATE OF DEATH Month July Day 12 Year 1967		
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-93	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Office Mgr. Distillery		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, Md.		11. BIRTHPLACE (County & State or foreign country) USA	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-6749		17. INFORMANT Address Mrs. Charlotte Loeschke (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER of BLADDER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blood Pressure drop					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/14 , 19 67 , to 7/11 , 19 67 , that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at 3-50 A.M. , from causes and on the date stated above.					
22a. SIGNATURE N. Eftekhari			M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/12/67
22c. PHYSICIAN'S NAME (Type) Dr. N. Eftekhari			22d. ADDRESS G.B.M.C. N. Charles St. Baltimore Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/15/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.			25a. REC'D BY REGISTRAR DATE JUL 12 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

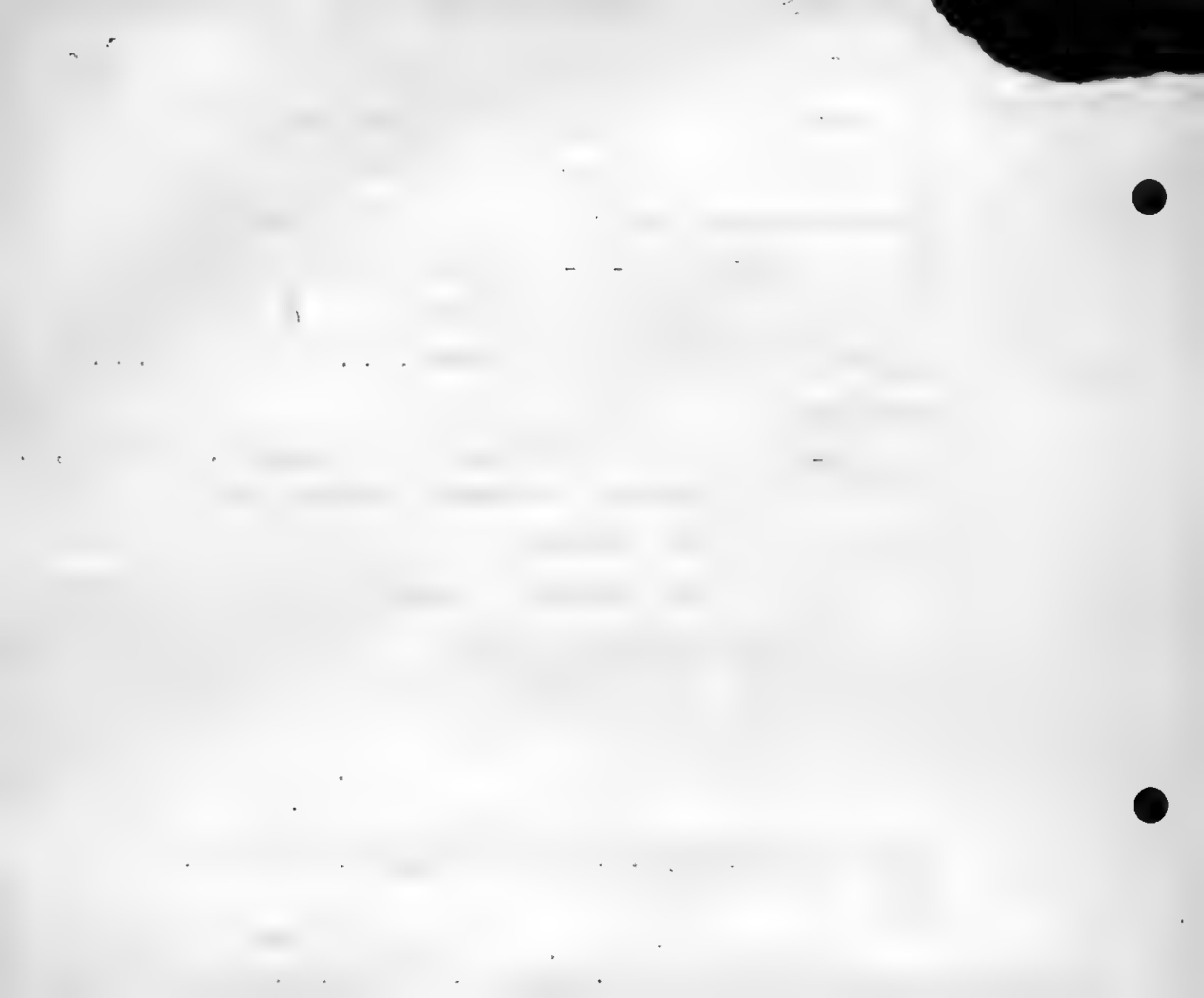
09252

CERTIFICATE OF DEATH

09251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN TB 16 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e STREET ADDRESS 1562 Clifton Avenue	
3 NAME OF DECEASED (Type or print) First SAMUEL Middle - - - Last LOGAN		4 DATE OF DEATH Month July Day 4 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/96 AGE (n years last birthday) yrs. 71
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY Construction	11 BIRTH PLACE (County & State, or foreign country) Sumter, S.C.
13. FATHER'S NAME Samuel Logan		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16 SOCIAL SECURITY NO 220 09 95 14	
17 INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md.		18. CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA, BILATERALLY, UNDETERMINED ORGANISM (b) BONE METASTASES (c) ADENOCARCINOMA OF PROSTATE	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTHRITIS LEFT KNEE, UNDETERMINED ETIOLOGY		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour : m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from May 19 19 67 to July 4, 19 67 that (X) (we) lost the deceased alive on July 4 19 67 , and that death occurred at 9:05 M. from causes and on the date stated above.			
22a. SIGNATURE Neilson Neilson M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 7/5/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		22d ADDRESS VA Hospital, Fort Howard, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 7-10-67	23c NAME OF CEMETERY OR CREMATORY BALTO NATIONAL	23d LOCATION (City or Town) (County) (State) BALTO MD
24 FUNERAL DIRECTOR Marshall P. Hayes		25a REGISTRY SIGNATURE Marshall P. Hayes 25b REGISTRY SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00253

CERTIFICATE OF DEATH

09253

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Pennsylvania b. COUNTY Dauphin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisburg 17112		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center				d. STREET ADDRESS 7186 Jonestown Rd.			
3. NAME OF DECEASED (Type or print) First Burt Middle Price Last Long				4. DATE OF DEATH Month 7 Day 10 Year 1967			
5. SEX M	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-94	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10		11. IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Miles G. Long				14. MOTHER'S MAIDEN NAME Sara A. Wingard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1917-1917		16. SOCIAL SECURITY NO. 172-01-3683		17. INFORMANT Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Ischaemic heart disease DUE TO (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH 16 hrs 80 years 25 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation for resection of abdominal aortic aneurysm 7-5-67							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 7, 1967 to July 10, 1967 , that (I) (we) last saw the deceased alive on July 10, 1967 , and that death occurred at 2:07 AM , from causes and on the date stated above							
22a. SIGNATURE Tom Poliness M.D.				22b. DATE SIGNED July 10 '67		22c. PHYSICIAN'S NAME (Type) TOM POLINESS	
22d. ADDRESS % CBMC, 6701 N. CHARLES ST., BALTIMORE MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY BLUE RIDGE MEMO		23d. LOCATION (City or Town) (County) (State) HARRISBURG PA	
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME				25a. REC'D BY REGISTRAR JUL 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jordan	
24. FUNERAL DIRECTOR FOR ZIMMERMAN FUNERAL HOME							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09250

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 Ritters Lane</u>		e. STREET ADDRESS <u>5 Ritters Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Albert</u> Last <u>Long Jr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 10, 1905</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Year <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employed State Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles A. Long Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Laura E. Hanson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-20-0577</u>	
17. INFORMANT <u>Mrs. Mary M. Long, Owings Mills, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Myocarditis - decompensating</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1-14-67</u> , 19 <u>67</u> , to <u>7-11-67</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>7-10-67</u> , 19 <u>67</u> , and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James G. Siffell</u>		22b. DATE SIGNED <u>7-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Siffell</u>		22d. ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 14, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>David Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>J.F. Eline & Sons, Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09255

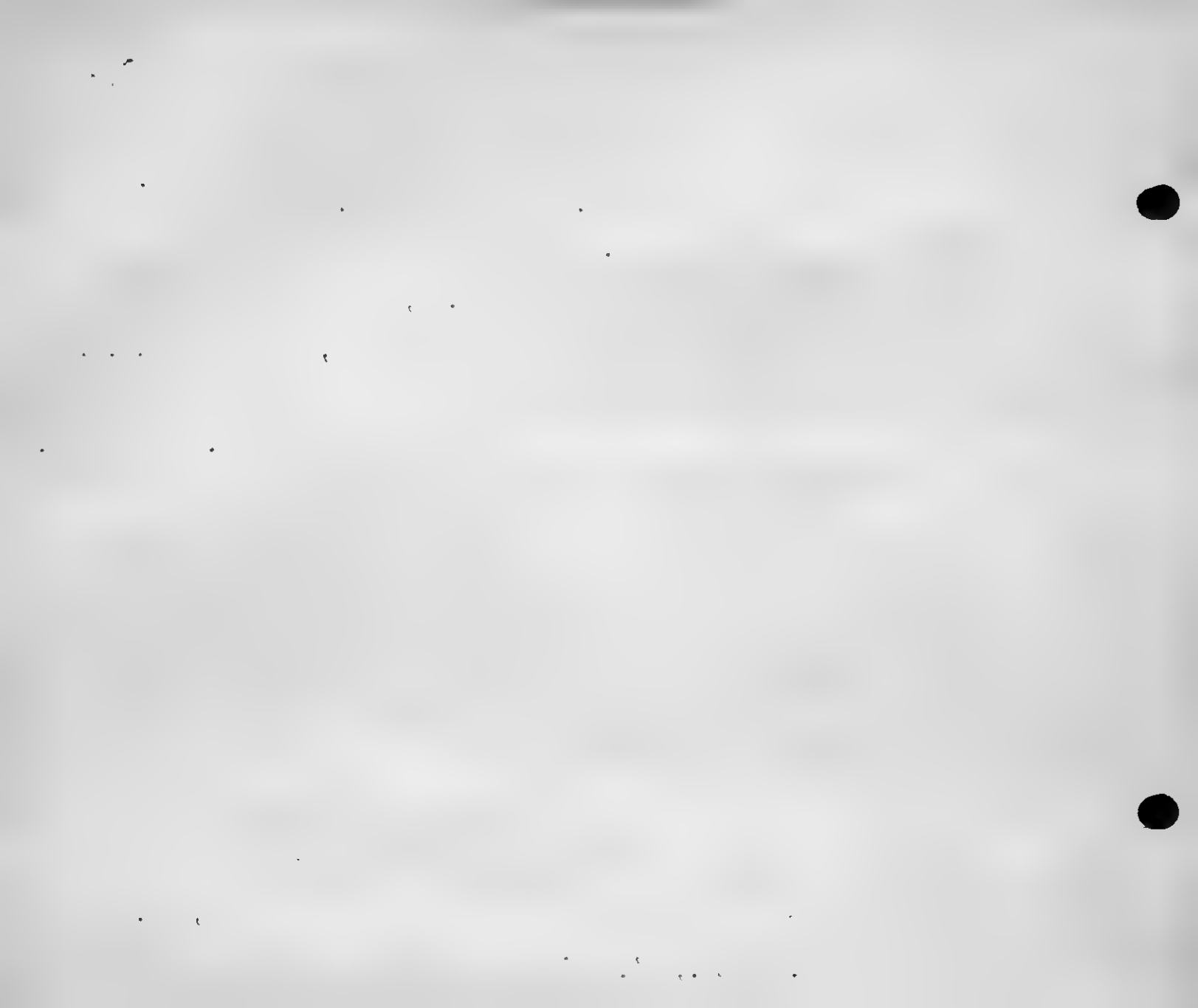
CERTIFICATE OF DEATH

09254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY L			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21228			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 6501 Frederick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL CHARLES LORENZ				4. DATE OF DEATH Month Day Year JULY 15 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/07		9. AGE (In years last birthday) 59 7/11		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rhinehart Lorenz				14. MOTHER'S MAIDEN NAME Louise Fisher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-08-88-56		17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA RECTO SIGMOID DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 107X						INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 30, 1967 to July 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 15, 1967 , and that death occurred 12:15AM from causes and on the date stated above.							
22a. SIGNATURE <i>Charles Judge</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/15/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR McNabb Funeral Home				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Presbyterian Home of Md.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 435 Simmons Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Georgia Middle E. Last LUBY						4. DATE OF DEATH Month July Day 1 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1888		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Andrew Satterfield						14. MOTHER'S MAIDEN NAME Joanna Mitchell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Presbyterian Home of Md. Towson, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERNICIOUS ANEMIA											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to July 1, 1967 , that (I) (we) last saw the deceased alive on JUNE 28, 1967 , and that death occurred at 11:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE S. J. VENABLE JR M.D.						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) S. J. VENABLE JR M.D.		22d. ADDRESS 7215 York Rd BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-5-67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City, town or county) Baltimore, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Mitchell-Wiedefeld Home, Inc.						25a. REC'D BY REGISTRAR JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09257

CERTIFICATE OF DEATH

09256

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 49 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1738 E. LANSVILLE STREET	
3. NAME OF DECEASED (Type or print) First Middle Last AMOS CORNELIUS LUCAS		4. DATE OF DEATH Month Day Year JULY 19, 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/14
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER	
11. BIRTHPLACE (County & State, or foreign country) RICHMOND, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS R. LUCAS		14. MOTHER'S MAIDEN NAME MAGGIE WASHINGTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO 212 16 01 33	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEPATIC METASIS (c) PULMONARY TUMOR, UNSPECIFIED TYPE, LEFT LUNG		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC ALCOHOLISM; RHEUMATIC HEART DISEASE, MITRAL INSUFFICIENCY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 6/5/31/67 , 19__, to 7/19/67 , 19__, that (I) (we) last saw the deceased alive on 7/19/67 , 19__, and that death occurred at 11:45 PM from causes and on the date stated above			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED 7/20/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/26/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR ELLIOT FUNERAL HOME		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME CAROLINE STREET, BALTIMORE, MD.	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chesapeake Manor Nursing Home				e. STREET ADDRESS Cold Spring Guilford Towers, 14			
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle SNOWDEN Last LUCCHESE				4. DATE OF DEATH Month JULY Day 9 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1876	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Frederick A. Lucchesi				14. MOTHER'S MAIDEN NAME Ida I. Masson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NC				16. SOCIAL SECURITY NO. 212-10-3294			
17. INFORMANT Niece				Address Balto., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio Scler. C-V disease DUE TO (b) C. A. Stomach (Inoperable) DUE TO (c) 2 kidney aneurysms				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 1 1/2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 66 , to 7/18 , 19 67 , that (I) (we) last saw the deceased alive on 7/18 , 19 67 , and that death occurred at 8:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE T. A. Sedlack				22b. DATE SIGNED 7/10/67		22c. PHYSICIAN'S NAME (Type) T. A. SEDLACK	
22d. ADDRESS 200 W. Penna Ave. Towson, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR ST. ANTHONY'S COMPANY, 108 North Av.,				25a. REC'D BY REGISTRAR JUL 11 1967		25b. REGISTRAR'S SIGNATURE W. L. ...	

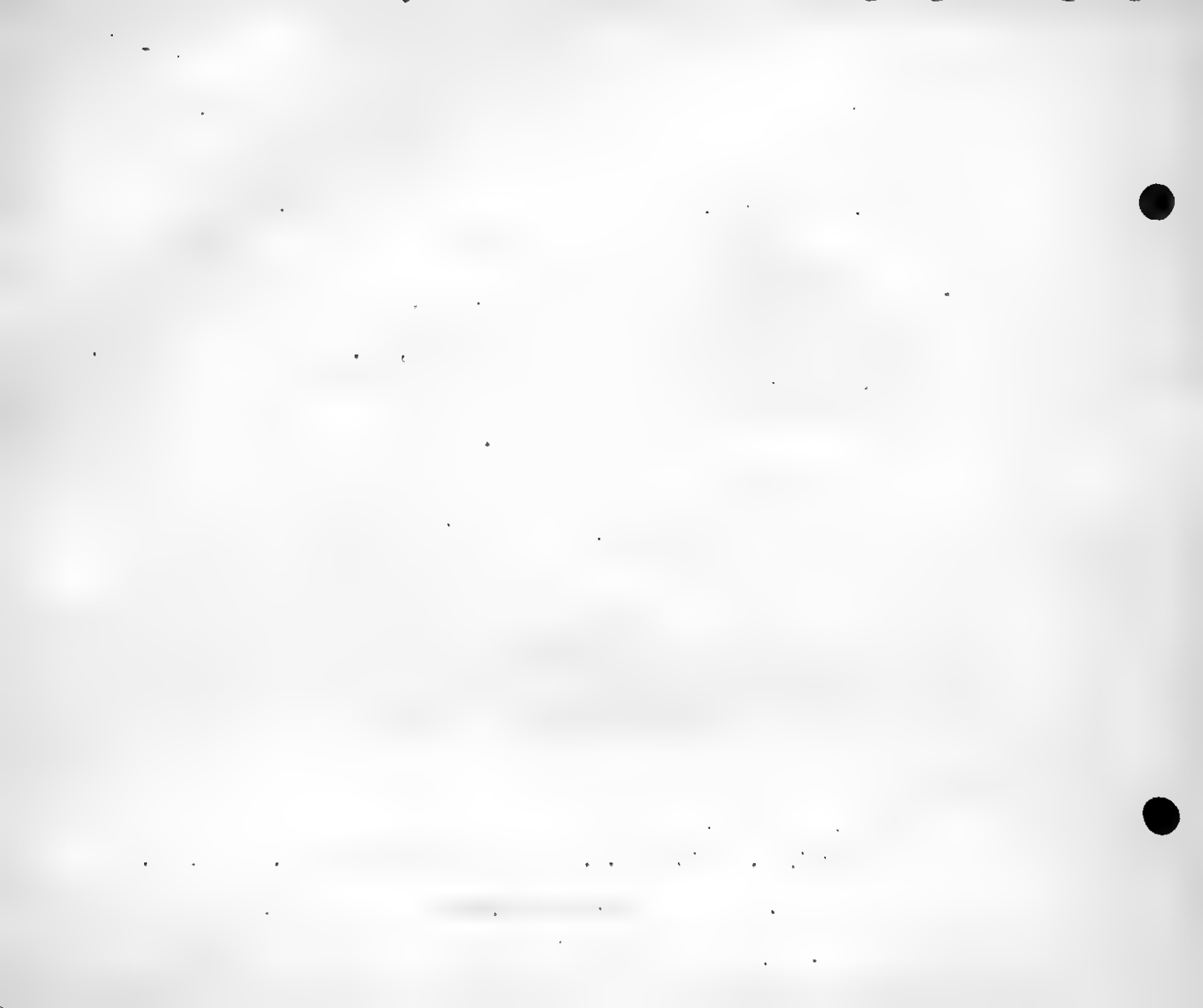
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 29 Cedar Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Lucke		4. DATE OF DEATH Month July Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1883
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roderick McInnis		14. MOTHER'S MAIDEN NAME Neta (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Frank Lucke		Address 29 Cedar Hill Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) MASCVN DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Eugenio E. Bonitez M.D.		22b. DATE SIGNED 7/5/67	
22c. PHYSICIAN'S NAME (Type) Eugenio E. Bonitez M.D.		22d. ADDRESS 3350 Wilkins Ave. Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 7/6/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION (City, town or county) (State) Woodlawn Balto Co Md	
24. FUNERAL DIRECTOR Loring Byers		25a. REC'D BY REGISTRAR JUL 7 1967	
ADDRESS 8728 Liberty Rd Md		25b. REGISTRAR'S SIGNATURE J. Charles Young	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
39260					39259					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN MD 10 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6012 Moorehead Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 6012 Moorehead Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rosina M. Ludwig			4. DATE OF DEATH July 28 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME George Fassel					14. MOTHER'S MAIDEN NAME Virginia Kimball					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT (Daughter) Mrs. Ida Wiessner, 6012 Moorehead Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Coronary Artery Disease causing (b) Complete Heart Block DUE TO Complete Heart Block (c) Complete Heart Block CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to 7/28 1967 , that (I) (we) last saw the deceased alive on 6/15 1967 , and that death occurred at 4:45 PM , from the causes and on the date stated above.										
22a. SIGNATURE James J. Nolan M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/29/67 22c. PHYSICIAN'S NAME (Type) James J. Nolan M. D. 22d. ADDRESS 1 Mallow Hill Rd. Catonsville, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					25a. REC'D BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr11mth26dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 72 Southgate Avenue	
3. NAME OF DECEASED (Type or print) Caroline M. Lutz		4. DATE OF DEATH July 23 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1896
9. AGE (in years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME J. August Lutz		14. MOTHER'S MAIDEN NAME Anna M. Butzen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 220-48-5350T	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia			
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis - Malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that she (this hospital) attended the deceased from July 27, 19 61 to July 23, 19 67 that (X) (we) last saw the deceased alive on July 23, 19 67 , and that death occurred at 6:35 PM , from causes and on the date stated above			
22a. SIGNATURE Stella Wachslor		22b. DATE SIGNED 7-23-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF July 27, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR Bev Riley E. Hopping		25a. REC'D BY REGISTRAR Charles Judge	
Hopping Funeral Home - Annapolis, Md.		DATE JUL 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09262

CERTIFICATE OF DEATH

09261

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN It		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6721 Hillendale Rd				d. STREET ADDRESS 6721 Hillendale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Albert Maestri				4. DATE OF DEATH Month Day Year 7-15-67 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-28		9. AGE (In years last birthday) 39 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Program Representative		10b. KIND OF BUSINESS OR INDUSTRY US Pub. Health		11. BIRTHPLACE (County & State, or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo Maestri				14. MOTHER'S MAIDEN NAME Katherine Levezzi			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 9-25-46 1-28-48		16. SOCIAL SECURITY NO. 432 34 9637		17. INFORMANT Address Catherine D. Maestri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH instantaneous	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 , to July 15, 1967 , that (I) (we) last saw the deceased alive on did not see 1967 and that death occurred at 4:45 M, from causes and on the date stated above.							
22a. SIGNATURE Worth Daniels, Jr.				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/16/67	
22c. PHYSICIAN'S NAME (Type) Worth Daniels, Jr.				22d. ADDRESS 11 E. Chase St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-17-67		23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery		23d. LOCATION (City or Town) (County) (State) Greenwood Arkansas	
24. FUNERAL DIRECTOR Wm. E. Johnson. 8521 Loch Raven Blvd. Balto. Md.				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

09275

09276

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodmoor</u>	
c. LENGTH OF STAY IN 16 <u>3 days</u>		d. STREET ADDRESS <u>3523 Essex Rd. 21307</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Clayton MAGEE</u>		4. DATE OF DEATH <u>July 13 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-17 1941</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frantz Mfg.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>John MAGEE</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hops Tetter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>234-10-4845</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION (CVA)</u> <u>331X</u> Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u>Rt Internal Carotid Artery Thrombosis</u> DUE TO (c) <u>ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>7-13</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-13</u> , 19 <u>67</u> , and that death occurred at <u>10:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Salvador A. Madamba</u> M.D.		22b. DATE SIGNED <u>7-13-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>7/14/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>Clarksburg, West Virginia</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Richmond Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 18 1967</u>			

CERTIFICATE OF DEATH

00263

00262

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1203 Elmridge Ave. 21229		d. STREET ADDRESS 1203 Elmridge Ave. 21229	
3. NAME OF DECEASED (Type or print) First Berniece Middle A. Last Mahoney		4. DATE OF DEATH Month July Day 8 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Arm. Div.		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	9 AGE (In years last birthday) 51 yrs
13. FATHER'S NAME - - - Wozniak		14. MOTHER'S MAIDEN NAME Helen - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 026-10-3349	
17. INFORMANT Mr. Joseph P. Mahoney, 1203 Elmridge Ave.		Address 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leiomysosarcina of the small intestine with metostasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) intestine with metostasis (c) lym.			INTERVAL BETWEEN ONSET AND DEATH lym.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to July 8 , 19 67 , that (I) (we) last saw the deceased alive on July 8 , 19 67 , and that death occurred at 3:25 P.M. from causes and on the date stated above			
22a. SIGNATURE Dr. Herbert J. Levickas		22b. DATE SIGNED 7/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. Herbert J. Levickas		22d. ADDRESS 5404 East Drive 1073xMaiden Lane CI2-1500	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/12/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JUL 11 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09264

CERTIFICATE OF DEATH

09263

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3401 Upton Road #21234	
3. NAME OF DECEASED (Type or print) Louis		4. DATE OF DEATH Month July Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Hendler's Ice Cream	11. BIRTHPLACE (County & State, or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Flaviano Maivelett	
14. MOTHER'S MAIDEN NAME D'Egidio Abruzzi		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO 215-03-2843		17. INFORMANT (nee Izzo) Address Antoinette Maivelett, wife, above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage - right side DUE TO 551X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 27, 1967 , to July 28, 1967 , that (I) (we) lost saw the deceased alive on July 28, 1967 , and that death occurred at 3:00A M. from causes on and the date stated above			
22a. SIGNATURE Elmo Gayoso		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type) Elmo Gayoso, M.D.		22d. ADDRESS 7620 York Road #21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane		25a. REC'D BY REGISTRAR AUG 1 1967 DATE 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09264

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c LENGTH OF STAY IN 1b 8 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 3712 Liberty Hts. Avenue	
3 NAME OF DECEASED (Type or print) CYPRYAN MALISZEWSKI		4 DATE OF DEATH July 5, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept 26 1893
9 AGE (in years last birthday) 73 y's		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired tailor		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Peter Malisewski		14 MOTHER'S MAIDEN NAME Catherine Piaseski	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 216-07-9695	
17 INFORMANT Malvin Pruchniewski		Address 313 Twin Oak Rd 21090	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Syncope during local anesthesia for broncoscopy DUE TO (b) Bronchogenic carcinoma of rt. lung with DUE TO (c) metastatic to liver and lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8) Syncope during local anesthesia for broncoscopy	
20c TIME OF INJURY Month Day Year Hour a.m. 8:15 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> PLACE OF INJURY (Home, farm, factory, street office, etc.) Hospital (City or town) Balto. (County) Balto. (State) MD.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 5, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF July 8 1967	23c NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d LOCATION (City or town) (County) (State) German Hill Rd Balto Md
24 FUNERAL DIRECTOR The Dippel Brothers Inc 1800 E Lombard St		25a REC'D BY REGISTRAR JUL 6 1967	25b REGISTRAR'S SIGNATURE J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

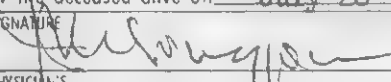

CERTIFICATE OF DEATH

09266

09267

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b 3 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS Box 127, Rte. 1	
3 NAME OF DECEASED (Type or print) E L M A		First Middle Last G. MARKLINE		4 DATE OF DEATH Month Day Year July 20 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 24, 1905	9 AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (County & State, or foreign country) Maryland (Towson)	
13. FATHER'S NAME Harry C. Greaser			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No ---			16. SOCIAL SECURITY NO. 220-48-7579		17. INFORMANT Louis E. Markline
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 331x IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			21131 INTERVAL BETWEEN ONSET AND DEATH		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (a) (this hospital) attended the deceased from July 18 , 19 67 , to July 20 , 19 67 , that (b) (we) lost saw the deceased alive on July 20 , 19 67 , and that death occurred at 9:45pM , from causes and on the date stated above.					
22a SIGNATURE 		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 7/20/67	
22c PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/24/1967	23c NAME OF CEMETERY OR CREMATORY Bethel		23d LOCATION (City or Town) (County) (State) Madonna, Maryland	
24 FUNERAL DIRECTOR Charles E. Kurtz		ADDRESS Jarrettsville, Md.		25a REC'D BY REGISTRAR DATE JUL 24 1967	25b REGISTRAR'S SIGNATURE 

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09267

FOR STATE HEALTH DEPT

39268

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 1619 E. Chase Street	
3 NAME OF DECEASED (Type or print) BLEASE		4 DATE OF DEATH Month July Day 20 Year 19 67	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 5, 1931
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 36 yrs	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wiley Hill S.C.	
13 FATHER'S NAME Agnes Martin		12 CITIZEN OF WHAT COUNTRY? USA	
14 MOTHER'S MAIDEN NAME Isabel McConer		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16 SOCIAL SECURITY NO. 251-44-3367		17 ADDRESS Delois Martin	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		22. DATE SIGNED July 22, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF 7-25-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore	23d. LOCATION (City or town) (County) (State) Baltimore
24. FUNERAL DIRECTOR Eloy O. Wilson		25a. REC'D BY REGISTRAR Jul 25 1967	
25b. REGISTRAR'S SIGNATURE William J. ...			



09269

CERTIFICATE OF DEATH

09269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore Towson		c. LENGTH OF STAY IN 1b 10 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d STREET ADDRESS 613 W. Seminary Avenue	
3 NAME OF DECEASED (Type or print) Mary Lee Matthews		4. DATE OF DEATH July 11 19 67	
5 SEX Female	6 COLOR OR RACE N	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/8/1900
9 AGE (In years last birthday) 66 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Joshua Staratt		14. MOTHER'S MAIDEN NAME Florence Myers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 212-32-2639	
17 INFORMANT Patient's chart		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1b.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1 , 19 67 , to July 11 , 19 67 , that (I) (we) last saw the deceased alive on July 11 19 67 , and that death occurred at 6:30 M. from causes and on the date stated above.			
22a SIGNATURE John E. Adams		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED 7/11/67
22c PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22d ADDRESS Greater Baltimore Medical Center	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/14/67	23c NAME OF CEMETERY OR CREMATORY St. Lukes	23d LOCATION (City or Town) (County) (State) Bethesda, Md. Co. Md.
24 FUNERAL DIRECTOR Wm. C. Schuman		25a REC'D BY REGISTRAR JUL 13 1967	
ADDRESS 1701 M. Calhoun St.		25b REGISTRAR'S SIGNATURE [Signature]	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00250

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7817 Sholar Rd.		d. STREET ADDRESS 7817 Sholar Rd.	
3 NAME OF DECEASED (Type or print) First MATILDA Middle MAYESKI Last 4 DATE OF DEATH Month July Day 8 Year 19 67		5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb 9, 1897	
10a US. A. OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Worker		10b KIND OF BUSINESS OR INDUSTRY Farm	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Stanley Bruzdinski		14 MOTHER'S MAIDEN NAME Frances Murawa	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216 54 0107	
17 INFORMANT William Mayeski		Address Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ① H-S-C-V- Disease 4301 DUE TO (b) ② Obesity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 1B) None	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 7/10/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.	
24 FUNERAL DIRECTOR Bruzdinski Funeral Home		ADDRESS 1407 Eastern Ave.	
25a REC'D BY REGISTRAR JUL 12 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

31

and

and

09270

09271

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Maryland			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore, 21212 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21212 d. STREET ADDRESS 5628 Clearspring Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) MARIE E. MCCARTHY First Middle Last			4. DATE OF DEATH July 6 19 67 Month Day Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-25-1899	9. AGE (In years lost birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Cashier		10b. KIND OF BUSINESS OR INDUSTRY Ladies Apparel		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Andrew J. Preller		
14. MOTHER'S MAIDEN NAME Mary Ann Gaff			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO 214-20-2494			17. INFORMANT Miss Anna B. Preller (Same) Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of the liver. 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute pulmonary edema.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 14, 19 67 , to July 6, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 6, 19 67 , and that death occurred at 1 AM , from causes and on the date stated above.					
22a. SIGNATURE 		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED July 6, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Reynaldo Orjuela-Gomez		22d. ADDRESS 7620 York Rd., Towson, 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE JUL 7 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NOTRE DAME INFIRMARY - VILLA JULIA</u>					d. STREET ADDRESS <u>VALLEY ROAD,</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SISTER REGINA PATRICE MCCARTHY</u>			First Middle Last		4. DATE OF DEATH <u>JULY 15 1967</u>		Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 15, 1910</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER (SISTER)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DANIEL MCCARTHY</u>					14. MOTHER'S MAIDEN NAME <u>REGINA MCCARTY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>207-40-0584</u>		17. INFORMANT <u>SISTER MARY MARGARET - VILLA JULIA</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 1 1 1</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>July 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 13</u> , 19 <u>67</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Harold H Burns</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 16, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Harold H Burns</u>					22d. ADDRESS <u>8106 Harford Rd. Balt. Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 18 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LICESTER MD</u>			23d. LOCATION (City, town or county) (State) <u>LICESTER MD</u>			
24. FUNERAL DIRECTOR <u>FARLEY-CAVANAUGH</u>					ADDRESS <u>6601 Frederick Rd</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Juanita yago</u>	

09273

CERTIFICATE OF DEATH

09272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY / c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6102 Frederick Rd.		d. STREET ADDRESS 6102 Frederick Rd.	
3 NAME OF DECEASED (Type or print) Mina E. McCurley		4. DATE OF DEATH Month July Day 18 Year 1967	
5 SEX F	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 29, 1886
9 AGE (In years lost birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Balto., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Late - Otto C. Emrich		14. MOTHER'S MAIDEN NAME Caroline Von Der Heide	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Mrs. Margaret Mary McCurley 6102 Frederick Rd. - 21228		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 12 mo 10 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-11-1967 , to 7-18-1967 , that (I) (we) just saw the deceased alive on 7-11-1967 , and that death occurred at 9:00 M., from causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher, Sr.		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.		22d. ADDRESS 6209 Frederick Ave.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/21/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR JUL 21 1967 DATE	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD 42 a, b, c & d (3-31-61) 11/67 ph & Item 89

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND Pa. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CATONSVILLE		c. LENGTH OF STAY IN 1b 7 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) STANLEY - LA NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARGARET Middle MCCURRY Last McCURRY		4. DATE OF DEATH Month JULY Day 31 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE CAU	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	9 AGE (in years last birthday) 81 8 24
11. BIRTHPLACE (County & State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME —		14. MOTHER'S MAIDEN NAME SLOAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT DEBBY BRILL		Address 1027 LAKE MONT AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septemic DUE TO (b) Asplenic DUE TO (c) Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/14 , 19 66 , to 7/31 , 19 67 , that (I) (we) last saw the deceased alive on 7/26 , 19 67 , and that death occurred at 10:00 A.M., from causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff, Jr.		22b. DATE SIGNED 7-31-67	
22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr., M.D.		22d. ADDRESS 4605 Edmondson Avenue, Balto, Md., 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-4-1967	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City or Town) (County) (State) PITTSBURG ALLEGHENY PA.
24. FUNERAL DIRECTOR WEBER FUNERAL HOME		25a. REC'D BY REGISTRAR 531 EDMONDSON AVE	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 2 1967	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>13</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foley</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>610 McHenry Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>McDermitt</u> Last <u></u>		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-87</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Hugh McDermitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Cole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-01-9011</u>			
17. INFORMANT <u>Mrs Anna Stratton</u> Address <u>Baltimore Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> (b) <u></u> (c) <u></u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Four years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>July 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8 July</u> 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Paul H Royse</u>		22b. DATE SIGNED <u>July 8/1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		22d. ADDRESS <u>1403 Foley L2 Pikesville Md 21208</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/12/1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Ortanna, Adams Co., Pa.</u>			
24. FUNERAL DIRECTOR <u>Robert J. [unclear]</u> ADDRESS <u>[unclear]</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u> DATE			
25b. REGISTRAR'S SIGNATURE <u>[unclear]</u>		25c. [unclear]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

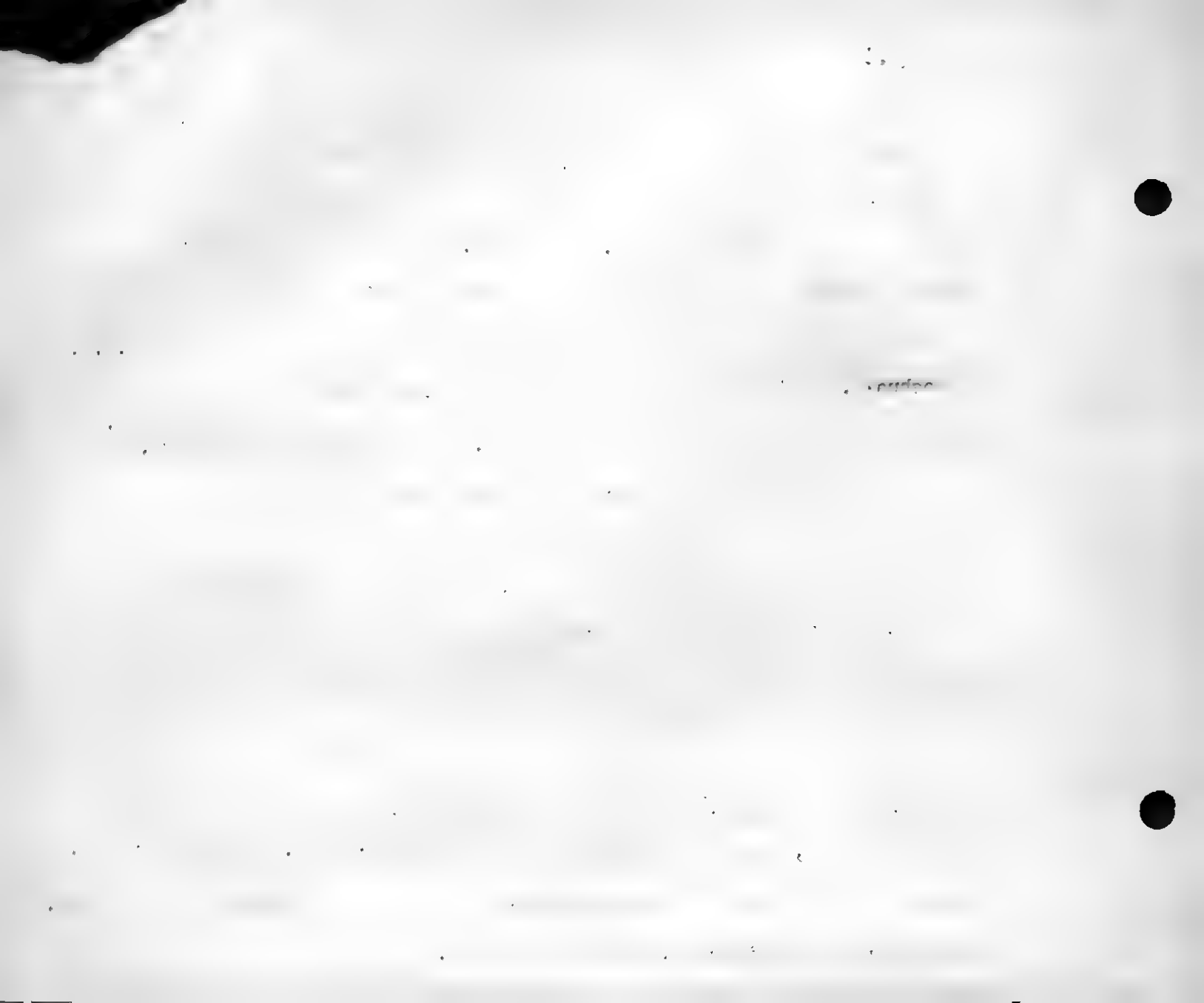
<div> <div>39277</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>09276</div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Point Yacht Club						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 5703 Whitby Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Gregory Last Megee			4. DATE OF DEATH Month July Day 24 Year 1967								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1961		9. AGE (In years last birthday) 5 yrs.		10. FUND 1 YEAR <input type="checkbox"/> FUND 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James G. Megee						14. MOTHER'S MAIDEN NAME Carol L. Kapp					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr & Mrs James G. Megee Address 5703 Whitby RD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING DUE TO (b) 2190 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Wandered away & apparently fell in water							
20c. TIME OF INJURY Month, Day, Year July 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Witt Park		20f. (City or town) Sparrows Pt - Balto Md (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE M.B. Davis				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 7/26/67			
EXAMINER'S NAME (Type) M.B. DAVIS - MD - 6804				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, City, town or county) Baltimore - Balto							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/6/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.				23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR Henry Sander & Sons inc. Balto. MD.						25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD.									
09278 CERTIFICATE OF DEATH 09277									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown			c. LENGTH OF STAY IN ID 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chapel Hill Nursing Home					d. STREET ADDRESS 3924 Susanna Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle G. Last Melvin			4. DATE OF DEATH Month July Day 7 Year 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5, 1893		9. AGE (In years) 73 yrs. IF UNDER 1 YEAR: Months 7 Days 3 IF UNDER 24 HRS: Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore city			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua O. Griffith					14. MOTHER'S MAIDEN NAME Agnes Naughton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT 3429 Susanna Rd. Mrs. Doris Manley Randallstown, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Dehydration + Difficulty in swallowing DUE TO (c) Generalized Arteriosclerosis + Parkinson's Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Numerous Large Decubiti									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-15-1967 , to 7-7-1967 , that (I) (we) last saw the deceased alive on 7-7-1967 , and that death occurred at 3 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Cesar Valle Caverio					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/8/67		
22c. PHYSICIAN'S NAME (Type) Dr, Cesar Valle Caverio					22d. ADDRESS 8629 Liberty Rd. Randallstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City, town or county) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Loring Byers					ADDRESS 8728 Liberty Rd Randallstown, Md.		25a. REC'D BY REGISTRAR JUL 10 1967		
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



CERTIFICATE OF DEATH

09278

09278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed in the Division of Vital Records within 72 hours after death.

1. NAME OF DECEASED (Type or Print) MIKUCKIS, PAULINA		2. DATE AND HOUR OF DEATH 7/3/67 4:22 A	
3. PLACE OF DEATH IN BALTIMORE-MARYLAND Baltimore County FULL NAME OF HOSPITAL OR INSTITUTION SHANGRI-LA NURSING HOME 333 HARLEM LANE, BALTO + 28		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1914 LETITIA AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 12/22/07
9. AGE (In years last birthday) 59		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Agejus Vakselis		14. MOTHER'S MAIDEN NAME Stefanie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-30-6006	
17. INFORMANT CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I BRAIN TUMOR ? GLIOMA 2) GRAND MAL SEIZURES 3) DIABETES MELLITUS 4) RECURRENT URINARY TRACT INFECTIONS		INTERVAL BETWEEN ONSET AND DEATH 4 y. 2 y. 2 y. 6 mo	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. I certify that (I) (this hospital) attended the deceased from NOV 14 1966 to JULY 3 1967 that (I) (we) last saw the deceased alive on July 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE E. Kasa		23B. DATE SIGNED 7/3/67	
23C. PHYSICIAN'S NAME (Type) E. KASAITIS, M.D.		23D. ADDRESS 1801 FREDERICK RD BALTIMORE, MD 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 7-7-67	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE RECEIVED BY HEALTH DEPT. JUL 6 1967		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

CERTIFICATE OF DEATH

09280

09279

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 Fusting Ave.		e. STREET ADDRESS 104 Woodlawn Ave.	
3. NAME OF DECEASED (Type or print) SARA CONWAY MILLER		4. DATE OF DEATH Month July Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1891
9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES COOK CONWAY		14. MOTHER'S MAIDEN NAME LIZZIE GRAY ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-3311	
17. INFORMANT Alice Kanley		Address 104 Woodlawn Ave., Balto. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anteroseptotic death disease DUE TO year Conditions, if any, which gave rise to immediate cause (b) Broncho-pneumonia stating the underlying cause last. 3 wks DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 24 , 19 67 , to July 3 , 19 67 , that (I) (we) last saw the deceased alive on June 27 , 19 67 , and that death occurred at 1 P.M. from causes and on the date stated above.			
22a. SIGNATURE Wetherbee Fort		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort		22d. ADDRESS 6 Dutton Ave, Catonsville 28.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.		25a. REC'D BY REGISTRAR JUL 7 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09280

FOR STATE
HEALTH DEPT.

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN Spam Pt - 19 c. LENGTH OF STAY IN 1b — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 Cumberland Mt. Pleasure Club		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4913 Denmore Ave. e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Theresa Anne Minko		4. DATE OF DEATH Month Day Year July 9th. 19 67	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1948
9. AGE (in years last birthday) 19 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Minko		14. MOTHER'S MAIDEN NAME Mary Ann Gregory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 216-52-9727	
17. INFORMANT John Minko, 4913 Denmore Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING DUE TO fall into Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO — (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Slipped from Saw Bar into deep water	
20c. TIME OF INJURY Month, Day, Year. 20 p.m. 7-9 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, city, street, office bldg., etc.) Ches. Bay	20f. City or town (County) (State) Spam Pt. Balto. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis, M.D. EXAMINER'S NAME (Type) 6800 Morningside Rd.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/67	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Simon		24a. REG. DAY REGISTRAR DATE JUL 11 1967	
24b. REGISTRAR'S SIGNATURE John P. O.		DATE SIGNED 7/10/67	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09281

FOR STATE
HEALTH DEPT.

09282

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b 1 Year		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1803 Homberg Avenue		d. STREET ADDRESS 1803 Homberg Avenue 21221	
3. NAME OF DECEASED (Type or print) LAWIE DORSEY MITCHELL		4. DATE OF DEATH Month 7 Day 5 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/24/38
9 AGE (In years last birthday) 28 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67	11 IF UNDER 24 HRS Hours 19 Minutes 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hot Strip Mill		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME H. Louis Mitchell		14. MOTHER'S MAIDEN NAME Ethel Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1956-1959		16. SOCIAL SECURITY NO 212-36-2749	
17. INFORMANT(Sister) Balto. Md. 21201		18. MOTHER'S MAIDEN NAME Mrs. Garnette Logan, 863 N. Howard St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrocranial injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple impacts to head DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck multiple times with an axe	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 7 5 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Baltimore Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i>		22. DATE SIGNED 7-6-67	
EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.		22. DATE SIGNED 7-6-67	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/67	23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE JUL 11 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b <u>7 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>8361 Ridgely Oak Rd</u>				
3. NAME OF DECEASED (Type or print) <u>Dorothy Katherine Moeller</u> First Middle Last					4. DATE OF DEATH <u>7/31/67</u> Month Day Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/1890</u>		9. AGE (in years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Peter Unkelbach</u>	
14. MOTHER'S MAIDEN NAME <u>Dora Ulrich</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>220-46-0763</u>		17. INFORMANT <u>Hospice records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>Asphyx</u> Conditions, if any, which gave rise to immediate cause (b) <u>Asphyx</u> (c) <u>Asphyx</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9/4/59</u> , 19....., to <u>7/31/67</u> , 19....., that (I) (we) last saw the deceased alive on <u>7/31/67</u> , 19....., and that death occurred at <u>10:09 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Robert J. Mahon</u> M.D.		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u>		22d. ADDRESS <u>204 E. Joppa Rd. Towson</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
23d. LOCATION (City, town or county) <u>Baltimore Maryland</u>		23e. REC'D BY REGISTRAR <u>AUG 2 1967</u>		23f. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		23g. REGISTRAR'S ADDRESS <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u>		23h. REGISTRAR'S DATE <u>AUG 2 1967</u>	

00284

CERTIFICATE OF DEATH

09283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balts. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IB <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>		e. STREET ADDRESS <u>5601 Newbury Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Christian Hummel Nornberger</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-18-01</u>
9. AGE (In years lost birthday) <u>65 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>estimator</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto. md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Henry Nornberger</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Heimlicher</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>316-32-9263</u>	
17 INFORMANT <u>patient's chart</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO <u>prof. internal hemorrhage</u> DUE TO <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>7/20/67</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/29</u> , 19 <u>67</u> , and that death occurred at <u>10 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Parviz Navidi</u>		22b. DATE SIGNED <u>7/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Gilmore</u>		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>August 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Maryland</u>
24 FUNERAL DIRECTOR <u>George Funeral - 3634 Falls Rd.</u>		25a REC'D BY REGISTRAR <u>William R. Klueber</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 3 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00285

00284

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>24 Acorn Circle</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>MNV</u> Middle <u>Marrison</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>73</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Steele, Janet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>Unk.</u>	
17. INFORMANT <u>Mrs. Janet Stahl</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Arteriosclerotic Cardiovascular and Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 27, 1967</u> , to <u>July 6, 1967</u> that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>2:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>José M. de León</u>		22b. DATE SIGNED <u>7/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSÉ M. DE LEÓN</u>		22d. ADDRESS <u>Greater Balto. Med. Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>7/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



00285

00286

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 7 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 37 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1640 N. FULTON AVENUE	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle E. Last NAPPER		4. DATE OF DEATH Month JULY Day 17 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/23
9. AGE (In years and months) 44 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TAXICAB COMPANY	
11. BIRTHPLACE (County & State, or foreign country) ALEXANDRIA, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD NAPPER		14. MOTHER'S MAIDEN NAME ANNA MN: CHASE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PL 28		16. SOCIAL SECURITY NO. 225 28 21 25	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO (b) Carcinoma left lung with stating the underlying cause last (c) metastasis to rt lung		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/10/67 , 19 to 7/17/67 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/17/67 , 19, and that death occurred at 10:15 PM from causes on and on the date stated above			
22a. SIGNATURE Ahmed Kutty		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) AHMED C.K. KUTTY M.D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/21/67	23c. NAME OF CEMETERY OR CREMATORY SNOWDEN CEMETERY	23d. LOCATION (City or town) (County) (State) ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR Kileen E. Egan		25a. REC'D BY REGISTRAR JUL 21 1967	
25b. REGISTRAR'S SIGNATURE John A. Judge		25c. ADDRESS 814 FRANKLIN ST. ALEXANDRIA, VA.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove farther papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b 19287 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3429 Chapman Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 3429 Chapman Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Nickoles Last Nickoles		4. DATE OF DEATH Month July Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1887
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Nickoles		14. MOTHER'S MAIDEN NAME Margaret Laughterbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-1900	
17. INFORMANT 3429 Chapman Rd. Mrs. Bessie M. Nickoles Randallstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO HAS CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/13/1963 to 6/26/1967 , that (I) was last saw the deceased alive on 6/26/1967 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE John Darrell		22b. DATE SIGNED 7/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell		22d. ADDRESS 9017 Liberty Road, Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/10/67	
23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial		23d. LOCATION (City, town or county) (State) Liberty Rd, Carroll Co, Md.	
24. FUNERAL DIRECTOR Loring Byers		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

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VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON Balto. c. LENGTH OF STAY IN b 33 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ARMACOST NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON, MD. d. STREET ADDRESS 934 DULANEY VALLEY RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE V. NIGHTINGALE First Middle Last 4. DATE OF DEATH JULY 4, 1967 Month Day Year		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH MAY 31, 1891 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER 10b. KIND OF BUSINESS OR INDUSTRY WOOD FLOORING PHILADELPHIA, PA. 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE NIGHTINGALE 14. MOTHER'S MAIDEN NAME SARAH DOTTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 160-07-6381 17. INFORMANT IRMA L. NIGHTINGALE, SAME AS ABOVE (Yes, no, or unknown) (If yes give year or dates of service) Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac arrest 1520 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO Coronary atherosclerosis with left hemiparesis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Several years INTERVAL BETWEEN ONSET AND DEATH 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from, 1963 , to July , 1967 , that (I) (we) last saw the deceased alive on July , 1967 , and that death occurred at 4:21 A.M. from the causes and on the date stated above.			
22a. SIGNATURE S. J. Liu M.D. 22c. PHYSICIAN'S NAME (Type) S. J. Liu M.D.		22b. DATE SIGNED July 4, 1967 22d. ADDRESS 5301 Harford Rd. Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7-4-67	
23c. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS HOSPITAL		23d. LOCATION (City, town or county) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison, DELTA, PA. ADDRESS		25a. REC'D BY REGISTRAR JUL 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09288

CERTIFICATE OF DEATH

09283

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>18 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1333 Dillon Hgts. Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last 4. DATE OF DEATH <u>7</u> <u>24</u> <u>1967</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-12-80</u> 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>XXXXXX, New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob Nunnold</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Messner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>219-05-9180</u> 17. INFORMANT <u>Mrs. Thelma B. Arold, 1560 Lister Rd. 21227</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia (G.U.)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>67</u> , to <u>7-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>67</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>David I. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-24-67</u> 22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u> 22d. ADDRESS <u>Linson Rd. - Cwings Mill, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/27/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>				24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> ADDRESS 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



09288

CERTIFICATE OF DEATH

09288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21215	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 4708 Wilern Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Rose Fannie Obertier		4. DATE OF DEATH Month Day Year July 31 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-11 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Hunovice		14. MOTHER'S MAIDEN NAME Sarah Hunovice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-165029	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive Air Way Disease DUE TO (b) with Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-1 , 19 67 to 7-31 , 19 67 , that (I) (we) last saw the deceased alive on 7-31 , 19 67 , and that death occurred at 10:59 AM , from causes on and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 7-21-67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/23/67	23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh Beth Israel	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.		25a. REC'D BY REGISTRAR DATE JUL 26 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09291

CERTIFICATE OF DEATH

09290

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 125 Waelchli Ave. 21227				d. STREET ADDRESS 125 Waelchli Ave. 21227			
3. NAME OF DECEASED (Type or print) First William Middle E. Last O'Loughlin				4. DATE OF DEATH Month July Day 8 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/87	
9. AGE (In years last birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter F. O'Loughlin				14. MOTHER'S MAIDEN NAME Annie E. Gisell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-6391		17. INFORMANT Address Mrs. Edith E. O'Loughlin, 125 Waelchli Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Failure DUE TO (b) Arterio Sclerotic Cardiovascular Disease DUE TO (c) Osteoar. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 60 , to 7/9, 1967 , that (I) (we) last saw the deceased alive on 7/9 1967 , and that death occurred at 7/9 1967 , from causes and on the date stated above.							
22a. SIGNATURE James N. Frederick M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/10/67	
22c. PHYSICIAN'S NAME (Type) James N. Frederick				22d. ADDRESS 1311 Francis Ave. CI2-5200			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR JUL 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09291

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN b. 6 mos. 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove S. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY BALTIMORE #21224. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #21224. d. STREET ADDRESS 507 S. 48th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA K. OLSEN. First Middle Last		4. DATE OF DEATH 7-4-1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1898 9. AGE (In years last b. rthday) 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANCIS JONECKI		14. MOTHER'S MAIDEN NAME LOUISE KNUSZCZYNSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-01-2980	17. INFORMANT Spring Grove S. Hosp. Records. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Cardiac Arrest. DUE TO (b) Arteriosclerotic Cardiovasc. disease DUE TO (c) Generalized Arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus - Pneumonia.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 67 to 7-4 , 19 67 , that (I) (we) lost saw the deceased alive on 7-4 , 19 67 , and that death occurred at 6:30 M, from causes and on the date stated above.			
22a. SIGNATURE Narciso W. Carmona M.D.		22b. DATES SIGNED 7-4-67	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA		22d. ADDRESS Spring Grove S. Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-8-67.	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	23d. LOCATION (City or Town) (County) (State) CT 7225 EASTERN BLVD. BA CO., MD
24. FUNERAL DIRECTOR Charles A. Geiler 6224 EASTERN AVE. BALTO., 21224, MD.		25a. REC'D BY REGISTRAR JUL 6 1967 DATE 25b. REGISTRAR'S SIGNATURE J. J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

09293

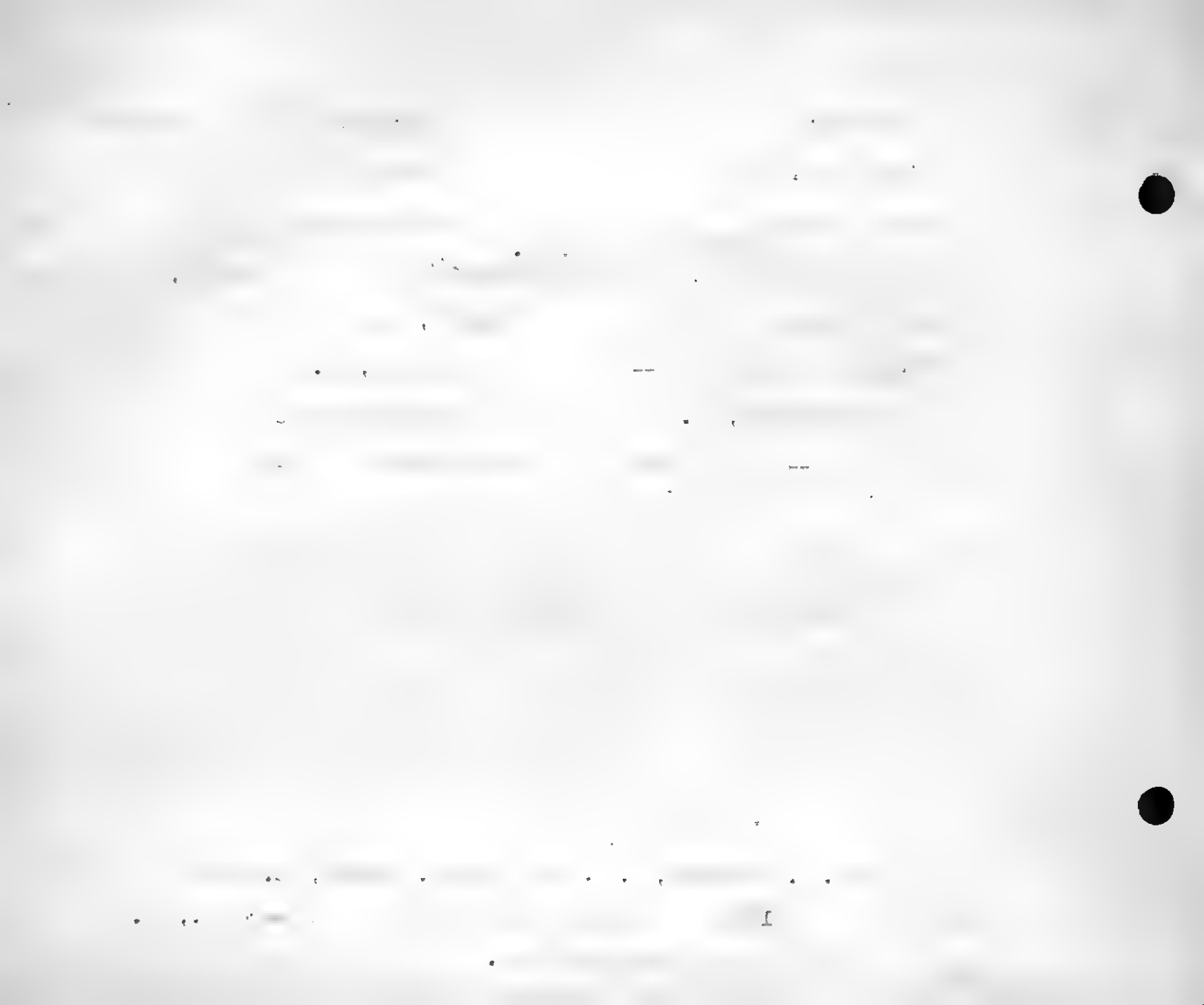
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09292

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Martin's Lagoon		d. STREET ADDRESS 1400 Nicholay Way	
3 NAME OF DECEASED (Type or print) PAUL OMREGCIK, JR.		4 DATE OF DEATH Month July Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Feb 25, 1952	9 AGE (In years lost birthday) 15 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --	11 BIRTHPLACE (State or foreign country) Baltimore, Md.
13 FATHER'S NAME Paul Omregcik, Sr.		14. MOTHER'S MAIDEN NAME Rebecca Nichols	
5 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO --	17 INFORMANT Rebecca Omregcik Address Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject was swimming across lagoon, yelled for help and disappeared beneath surface of water.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 p.m. 7/28 19 67		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Martins Lagoon
20f. (City or town) Essex		20g. (County) Balto Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo. C. Patterson		22. DATE SIGNED 7/31/67	
EXAMINER'S NAME (Type) Theo. C. Patterson, M. D.		22. DATE SIGNED 7/31/67	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE THEREOF 8/1/67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION (City or town) (County) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR Brudzinski Funeral Home		25. RECEIVED BY REGISTRAR JUL 31 1967	
24. FUNERAL DIRECTOR Brudzinski Funeral Home		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00294

00293

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN ID 1 Year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 944 Elmridge Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 944 Elmridge Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louisa M. Middle Panzone Last 				4. DATE OF DEATH Month July Day 14, Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-1886	
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Italy	
13. FATHER'S NAME Felice De Nicola				14. MOTHER'S MAIDEN NAME Gaetano Matucci			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 		17. INFORMANT Vincent Panzone 2542 W. Lanvale St. Address Balto. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Terminal Myocardial Infarction DUE TO (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from , 19 , to , 19 , that (I) (we) last saw the deceased alive on , 19 , and that death occurred at 11:00 M, from the causes and on the date stated above.							
22a. SIGNATURE John C. Hickey M.D.				22b. DATE SIGNED 7/17/67		22c. PHYSICIAN'S NAME (Type) Hatcharpe, M.D.	
22a. SIGNATURE John C. Hickey M.D.		22b. DATE SIGNED 7/17/67		22c. PHYSICIAN'S NAME (Type) Hatcharpe, M.D.		22d. ADDRESS 	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR G. Truman Schwab ADDRESS 3512 Frederick Ave, Balto. Md.				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

09281

09285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers., Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY in 1b 1 hour		d. STREET ADDRESS 909 Southerly Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Towson, Y.M.C.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jessie Sherman Penhallegon		4. DATE OF DEATH Month July Day 20 Year 1967	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1893
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months 7 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Baptist Book Publishing Co.		10b. KIND OF BUSINESS OR INDUSTRY ILL.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton A. Sherman		14. MOTHER'S MAIDEN NAME Ida Goodrich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 349 26 6176	
17. INFORMANT J.S. Penhallegon, 2220 Foxley Rd.		Address 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTEROSCLEROTIC HEART DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 1963 to JUL 20, 1967 , that (I) (we) lost saw the deceased alive on JUL 7, 1967 , and that death occurred on 3P M, from causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		22b. DATE SIGNED July 21, 1967	
22c. PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski		22d. ADDRESS 206 W. Pennsylvania Ave, Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7-24-67	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City or Town) (County) (State) Evanston Ill.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09296

CERTIFICATE OF DEATH

09295

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 534 Hampton Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD W. PINEAU		4. DATE OF DEATH July 1, 1967			
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1910	9. AGE (In years lost birthday) 56 yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self		10b. KIND OF BUSINESS OR INDUSTRY Roofers, Inc.		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME Leonard Pineau		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Lillian Pineau, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) arteriosclerotic heart disease & failure DUE TO (c) Hypertensive C.V. disease					INTERVAL BETWEEN ONSET AND DEATH Immediate 1 1/2 yrs 15 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ankylosing spondylitis with aortic insufficiency					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 21, 1959 , to June 2, 1967 , that (I) (we) last saw the deceased alive on June 2, 1967 , and that death occurred at 7 P.M. from causes and on the date stated above.					
22a. SIGNATURE Harry F. Klinefelter		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. F. KLINEFELTER		22d. ADDRESS 530 N. BROADWAY, BALTO, 21205			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	
				23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,		ADDRESS 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR JUL 6 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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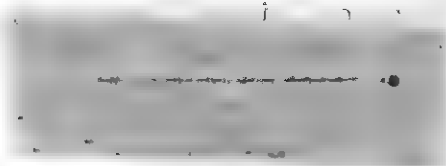
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09297

CERTIFICATE OF DEATH

09296

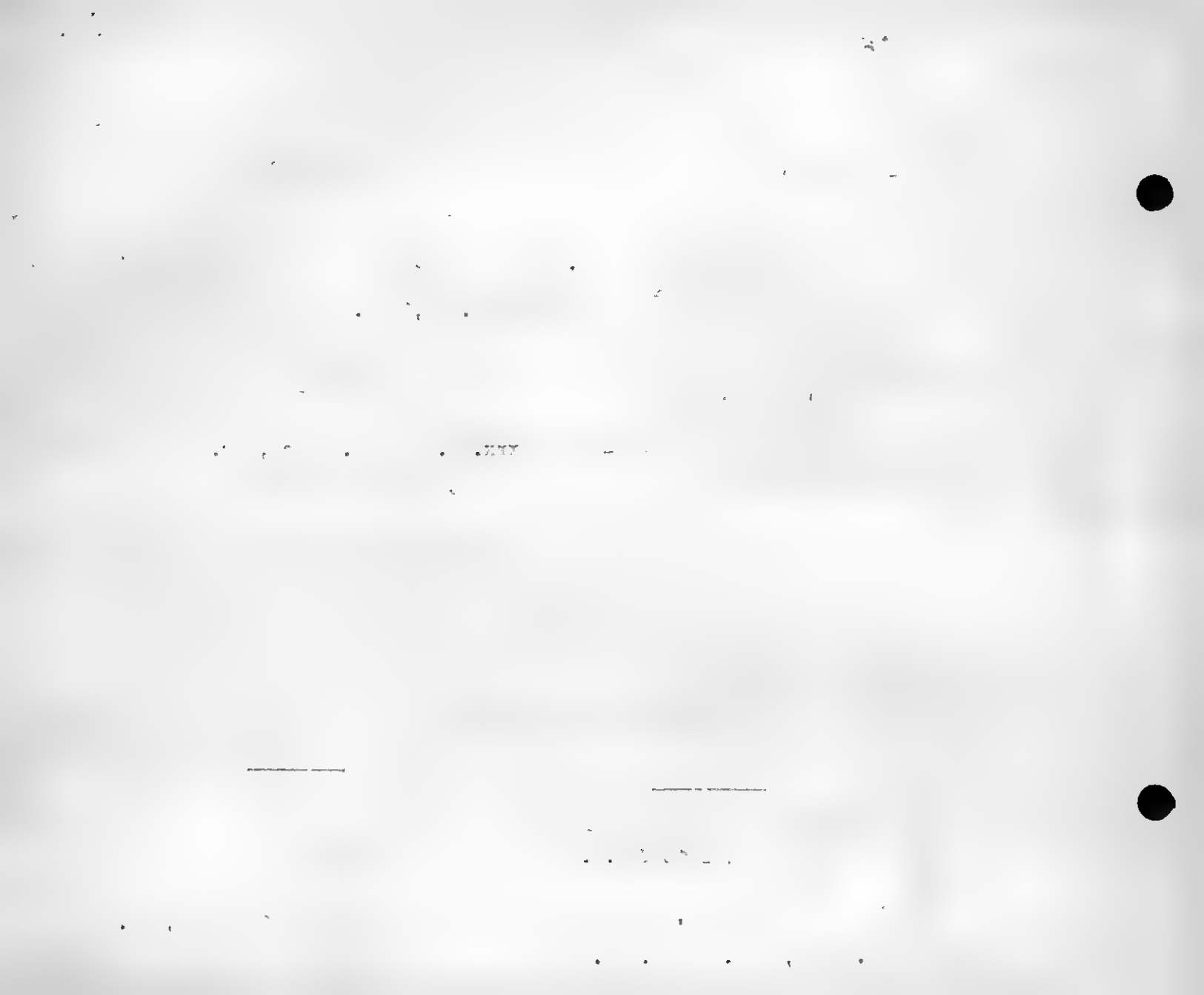
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b XXXXX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 4217 Ivanhoe Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Agnes Irene Price				4 DATE OF DEATH Month Day Year 7-16-1967			
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 28, 1892		9 AGE (In years last birthday) 75 yrs.	10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Texas, Maryland		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George F. Price				14. MOTHER'S MAIDEN NAME Rose Barrett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None		17 INFORMANT Address Frank B. Price, Sr. 4217 Ivanhoe Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15 , 19 67 , to July 16, 1967 , that (I) (we) last saw the deceased alive on July 16 , 19 67 , and that death occurred at 4:10AM , from causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED July 16, 1967	
22c. PHYSICIAN'S NAME (Type) Ismael Jamora				22d. ADDRESS 7620 York Rd., Baltimore Co., Md. 21212			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/67		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Garden		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John A. Ibran, Inc. 3000 E. Baltimore St.				25a. REGD BY REGISTRAR JUL 18 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Baltimore c. LENGTH OF STAY IN 1b Baltimore 21234 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2627 Windsor Road		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 2627 Windsor Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle E. Last PRICE		4 DATE OF DEATH Month July Day 24 Year 19 67	
5. SEX Female 6 COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Nov. 17, 1908. 9 AGE (In years, months, days, hours, minutes) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William McKinley		14 MOTHER'S MAIDEN NAME Elizabeth Kelly	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 218-28-4510	
17 INFORMANT Mrs. Mr. John W. Price, Sr. Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 7/24/67	
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF 7/27/67.	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS		25a. REC'D BY REGISTRAR JUL 25 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

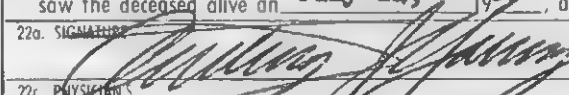

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00293

00293

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 11yr7mth2dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 2 Aberdeen Avenue		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Maude Middle Smith Last Proctor			4. DATE OF DEATH Month JULY Day 24 Year 1967		
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 1, 1889		9 AGE (In years last birthday) yrs 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John			14. MOTHER'S MAIDEN NAME Ellen Kilcop		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 022-18-5098	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction,					INTERVAL BETWEEN LONGEST AND DEATH 1 day
DUE TO (b) Arteriosclerotic Cardiovascular Heart Disease					20 years
DUE TO (c) Arteriosclerosis, generalized, senile					20 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Pneumonia, bilateral, bronchial, organism unk.; uremia & arterioneurosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Dec. 22, 1955 to July 24, 1967 , that (b) (we) last saw the deceased alive on July 24, 1967 , and that death occurred at 8:35P M, from causes and on the date stated above.					
22a. SIGNATURE 			M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED July 24, 1967
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/27/67	23c. NAME OF CEMETERY OR CREMATORY Mount Wollaston Cemetery		23d. LOCATION (City or Town) (County) (State) Quincy, Mass.	
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.			25a. RECD BY REGISTRAR MA JUL 27 1967		25b. REGISTRAR'S SIGNATURE 



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS 710 Evesham Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) (FEMALE) Dawn Marie						PTAK		4 DATE OF DEATH Month 7 Day 2 Year 19 67			
5 SEX Female		6 COLOR OR RACE Cau.		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6/30/67		9 AGE (In years last birthday) yrs		10 UNDER 1 YEAR Months 3 Days 3 Hours 3 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Francis Louis Ptak						14. MOTHER'S MAIDEN NAME Marie Vasquez					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO None		17 INFORMANT Mr. Francis L. Ptak			Address (Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7/30 IMMEDIATE CAUSE (a) Digitalis toxicity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 HRS.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spleen Menbrant Disease											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Digitalis intoxication during rapid digitalization							
20c. TIME OF INJURY Month, Day Year 30 July 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d., etc.) Hospital			20f. (City or town) (County) (State) Baltimore		
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 7/3/67		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/5/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE JUL 5 1967			25b. REGISTRAR'S SIGNATURE Charles J. Jones		

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial cremation or removal.

1. NAME OF DECEASED (Type or Print) <i>Mary</i> Marie Purcochar		2. DATE AND HOUR OF DEATH 7/30/67	
3. PLACE OF DEATH IN BALTIMORE-MARYLAND BALTIMORE COUNTY (If not in hospital or institution, give street address or location) 3402 Essex Rd Baltimore, Md 21207		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3402 Essex Rd	
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug 15, 1882
9. AGE (in years last birthday) 84		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Czech		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I CAUSE OF DEATH <i>Septicemic shock secondary to severe cystitis & decubitus ulcers</i> (A) DUE TO (B) <i>Acute cystitis</i> (C) <i>Decubitus ulcers</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>1 mo</i> <i>5 mo</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT <i>Hypertension & arteriosclerosis - Cor Pulmonale & right heart failure</i>		20. I certify that (I) (this hospital) attended the deceased from <i>Oct 1963</i> to <i>July 22, 1967</i> that (I) (we) last saw the deceased alive on <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
21A. SIGNATURE <i>James A. Cohen</i> M.D. 21B. ADDRESS M.D.		22. DATE SIGNED 7/31/67	
23A. PHYSICIAN'S NAME (Type)		23B. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/2/67	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem		24D. LOCATION (City, town, or county) (State) A A Co Md	
25A. DATE REC'D BY HEALTH DEPT AUG 7 1967		25B. NAME OF REGISTRAR <i>Frank J. [illegible]</i>	
25C. FUNERAL DIRECTOR McGully FH 227		25D. ADDRESS	

00302

CERTIFICATE OF DEATH

00301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>8007 Green Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Leah R. Randall</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Brodbeck</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Raffenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>MR. Charles Randall - Randallstown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrhythmia - 3</u> DUE TO (b) <u>Coronary Thrombosis - Myocardial infarct</u> DUE TO (c) <u>CORONARY Heart disease, severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>3 mo</u> <u>3 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1967</u> , to <u>July 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1967</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Simeon Calle</u>		22b. DATE SIGNED <u>7-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Simeon Calle</u>		22d. ADDRESS <u>BALTO. County Gen. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brodbecks PA.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>	
ADDRESS <u>Lysacville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1636 Hardwick Rd.					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1636 Hardwick Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frederick P. Rappe			First Middle Last		4. DATE OF DEATH July 23		Day Year 19 67		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 16, 1915		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY		
13. FATHER'S NAME Henry					14. MOTHER'S MAIDEN NAME Roberts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 2nd W.W. 213-05-4151		17. INFORMANT Wife		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) this hospital attended the deceased from March, 1967 , to July, 1967 , that (I) was last saw the deceased alive on 2 July 1967 , and that death occurred at 11 PM , from the causes and on the date stated above.									
22a. SIGNATURE Wm. H. Kammer Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 24 July 1967		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.		23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR P.A. Heemann					ADDRESS 6067 Harford Rd.				
25a. REG. BY REGISTRAR July 28 1967					25b. REG. BY REGISTRAR July 28 1967				

CERTIFICATE OF DEATH

09304

09303

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville, 21208</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1728 Reisterstown Road, Pikesville, Md.</u>		d. STREET ADDRESS <u>1728 Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>Albert</u> Last <u>Rock</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1936</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>John Rock</u>		14. MOTHER'S MAIDEN NAME <u>Laura Harlan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-01-4920</u>	
17. INFORMANT <u>Mrs. Kathleen Seal, 1728 Reisterstown Rd.</u>		Address <u>Pikesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42 yrs. arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>few years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>July 15, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>14 July 1967</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul H. Royse</u> M.D.		22b. DATE SIGNED <u>July 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE</u>		22d. ADDRESS <u>1403 Foley Lane, Pikesville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>15, 1967</u>		23b. DATE THEREOF <u>15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09305

CERTIFICATE OF DEATH

09304

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 c. LENGTH OF STAY IN TB 4		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore #21206 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS Box 296, Ridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Clara E. Royahn		4. DATE OF DEATH Month July Day 22 Year 1967	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 13, 1930
9 AGE (In years last birthday) yrs 37		10 IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Calvin Shaffer		14. MOTHER'S MAIDEN NAME Mary Elizabeth Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-46-1860	
17 INFORMANT Mr. William B. Stansbury Jr.		Address Trust Bldg 403 Mercantile	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary thromboembolism DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute fibrinopurulent pericarditis			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from July 13, 1967 , to July 22, 1967 that (b) (we) last saw the deceased alive on July 22, 1967 , and that death occurred at 1 p.m. from causes and on the date stated above.			
22a SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED July 22, 1967	
22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Road, Towson 4, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7-25-1967	
23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Md.	
24 FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25a REC'D BY REGISTRAR DATE JUL 25 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09305

FOR STATE
HEALTH DEPT.

C9306

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH'S HOSPITAL		d STREET ADDRESS 3031 CALIFORNIA AVE.	
3 NAME OF DECEASED (Type or print) JAMES		4 DATE OF DEATH Month 7 Day 22 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-29-23
9 AGE (In years past birthday) yrs 44		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABLE REPAIRMAN		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12 CITIZENSHIP OF WHAT COUNTRY?	
13 FATHER'S NAME JOHN RUBY		14 MOTHER'S MAIDEN NAME HANNA LYNCH	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW 2		16 SOCIAL SECURITY NO 215-12-5780	
17 INFORMANT ELWOOD RAWLINGS		Address 8325 ELLEN AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Francis X. Carmody		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANCIS X. CARMODY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 7-22-67		DEPT. MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/27/67	23c NAME OF CEMETERY OR CREMATORY Baltimore National	23d LOCATION (City or Town) (County) (State) Baltimore Maryland
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214		25a REC'D BY REG. STRAR JUL 25 1967	
25b REG. STRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09307

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>				d. STREET ADDRESS <u>501 Castle Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>L.</u> Last <u>SCHAEFER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 6, 1882</u>		9. AGE (In years last birthday) yrs. <u>84</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shower</u>				14. MOTHER'S MAIDEN NAME <u>Ross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-3648</u>		17. INFORMANT <u>Mr. Wm. F. Schaefer</u> Address <u>602 St. Francis Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last } (b) <u>Occlusion of right coronary artery</u> (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status post colectomy</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>July 5, 19 67</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>July 5, 19 67</u> , and that death occurred at <u>2:05 PM</u> , from causes on and on the date stated above							
22a. SIGNATURE <u>M.S. Cockburn</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>July 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.S. Cockburn, M.D.</u>				22d. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Buried</u>		23b. DATE THEREOF <u>7/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorriane Park Mausoleum</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson</u>				25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1200



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CERTIFICATE OF DEATH

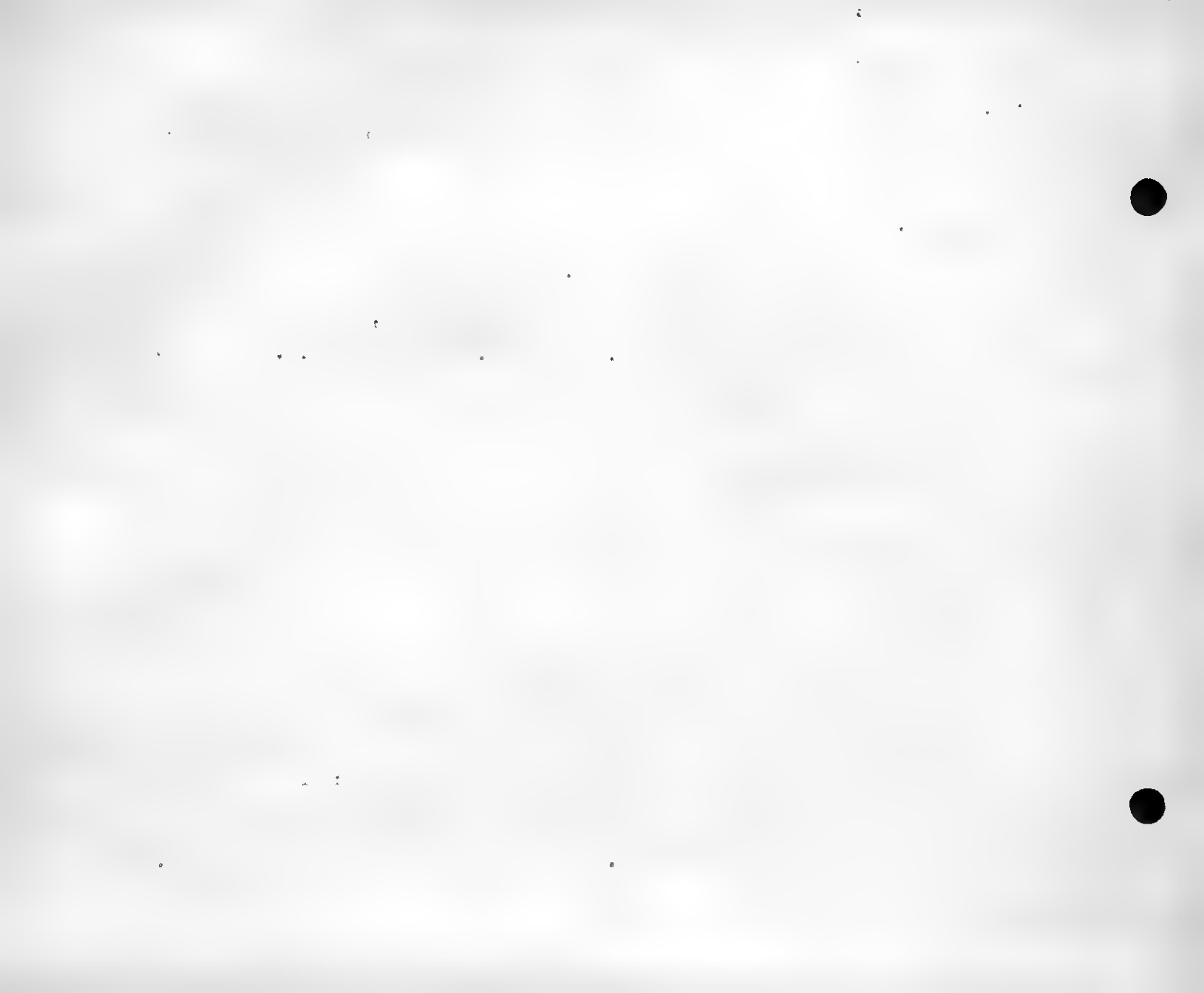
09306

09307

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MIDDLE RIVER		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1416 Third Road #21220	
3. NAME OF DECEASED (Type or print) First William Middle B. Last Schratz		4. DATE OF DEATH Month July Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1900
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glenn L. Martin Co. INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN SCHRATZ		14. MOTHER'S MAIDEN NAME BARBARA OBERHOFFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) VMK		16. SOCIAL SECURITY NO 109-05-0872	
17. INFORMANT FRANCES SCHRATZ		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis left coronary artery DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia secondary to chronic pyelonephritis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 5, 1967 , to July 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 30, 1967 , and that death occurred at 11:20 PM from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED July 31, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL	23d. LOCATION (City or Town) (County) (State) BALTO. MD.
24. FUNERAL DIRECTOR J.E. CONNELLY SONS		25a. RECO BY REGISTRAR AUG 3 1967	
ADDRESS 300 MACE		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09303

CERTIFICATE OF DEATH

09308

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MILFORD MANOR NURSING HOME				d. STREET ADDRESS 3903 BARRINGTON ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENA SCHULTZ				4. DATE OF DEATH JULY 7, 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEPA BLUMBERG				14. MOTHER'S MAIDEN NAME MOTLA ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MR. DAVID SCHULTZ, 5511 GIST AVENUE #15			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary Edema DUE TO (b) Arteriosclerosis C.V.D. & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 12 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-5- , 19 64 , to 7-7- , 19 67 , that (I) (we) last saw the deceased alive on 7-7- , 19 67 , and that death occurred at 3:30 M, from causes and on the date stated above.							
22a. SIGNATURE DR. HARVEY FUERERMAN		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/7/67			
22c. PHYSICIAN'S NAME (Type) DR. HARVEY FUERERMAN		22d. ADDRESS 6210 PARK HEIGHTS AVENUE					
23a. BURIAL SPECIALLY REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/7/67		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.				25a. REC'D BY REGISTRAR DATE JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

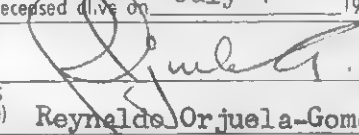



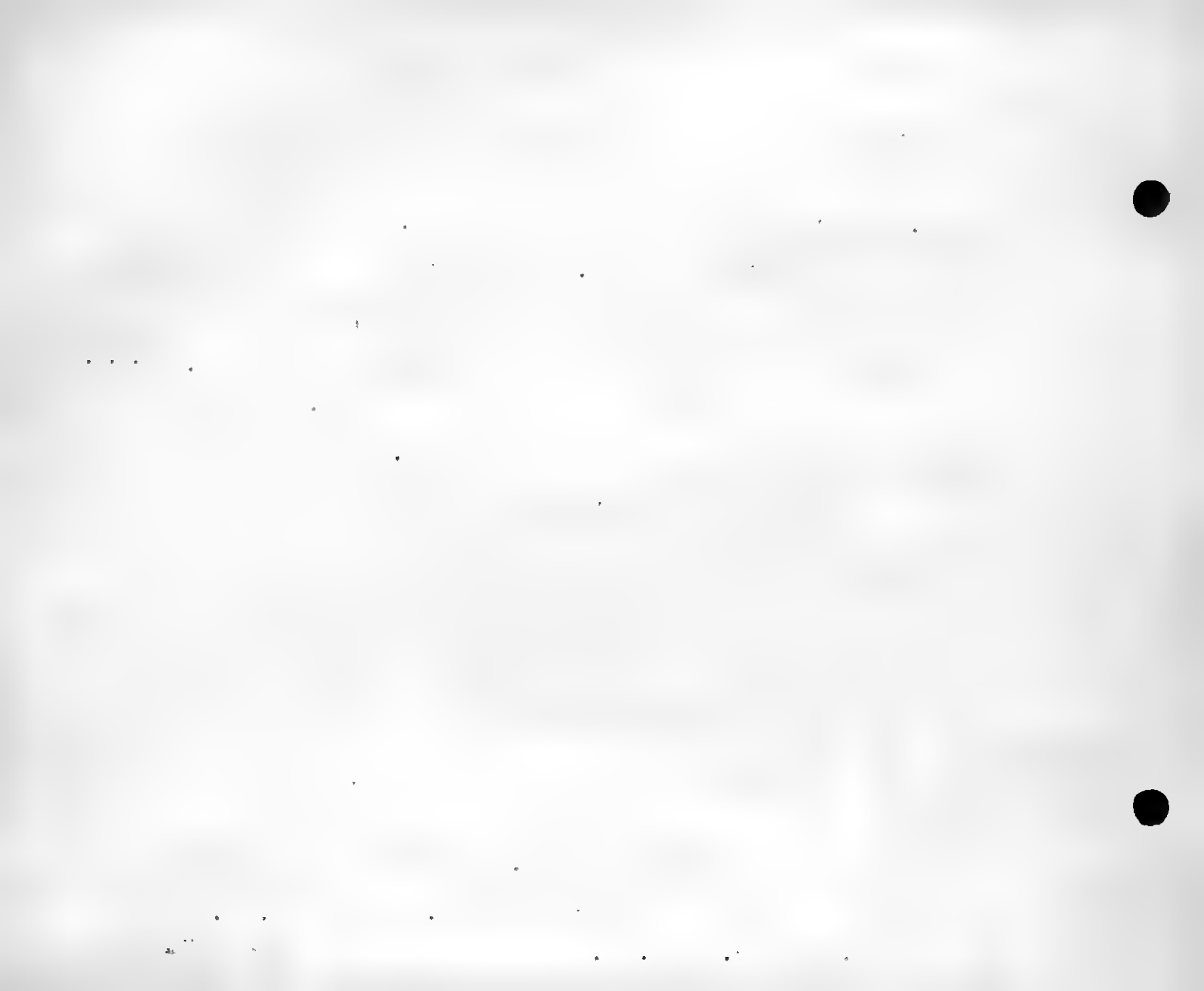
09309

CERTIFICATE OF DEATH

09310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 16 Baltimore #21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 106 E. Elm Avenue	
3 NAME OF DECEASED (Type or print) Thelma M. Schultz		4. DATE OF DEATH Month July Day 4 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 1, 1912
9 AGE (In years lost birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min. 55 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Schuylkill Haven, Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reed		14. MOTHER'S MAIDEN NAME Hattie Wood Bolton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Norman W. Schultz		Address same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)		20g (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 24 , 19 67 , to July 4 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 4 , 19 67 , and that death occurred at 6:05 AM , from causes and on the date stated above			
22a SIGNATURE 		22b. DATE SIGNED July 4, 1967	
22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/7/67	23c NAME OF CEMETERY OR CREMATORY Moreland Park Cem.	23d LOCATION (City or town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR JUL 5 1967	
25b REGISTRAR'S SIGNATURE 			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
BM 1/67

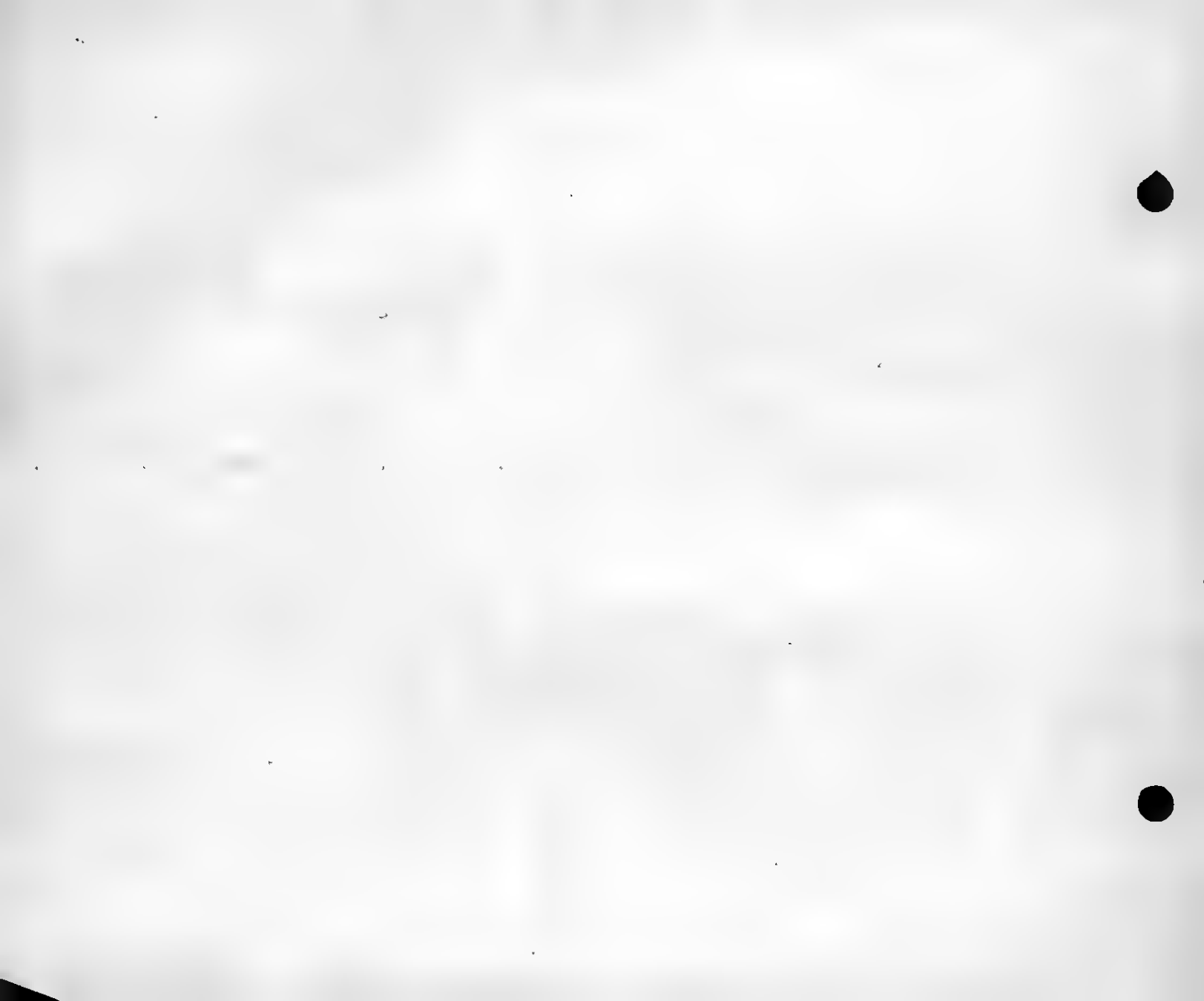
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO RURAL Fullerton</u>		c LENGTH OF STAY IN b <u>2 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8620 Belair Rd 21736</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>ANTON William Seymour</u>		4 DATE OF DEATH <u>July 7 19 67</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1 Mar 1889</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>- - - Seymour</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-10-3274</u>	
17 INFORMANT <u>Mr. Adolph W. Seyer, Waterloo Rd., Md.</u>		Address <u>Ellicott City, Md.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthritis.</u> (c) <u>Interval between onset and death</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis.</u> 19 WAS A TISSUE PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		22. DATE SIGNED <u>7-10-67</u>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		Address (Street, city, town, or county)	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/11/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24 FUNERAL DIRECTOR <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Ave. 21229</u>		25a REC'D BY REG. STRAR <u>JUL 13 1967</u> 25b REG. STRAR'S SIGNATURE <u>[Signature]</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY N 1b <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine Ridge Golf Course, Dulaney Valley Rd.</u>		d. STREET ADDRESS <u>2108 Northcliff Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Albert Memie Shaivitz</u>		4 DATE OF DEATH <u>July 30, 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 11, 1915</u>
9 AGE (In years lost birthday) <u>52</u> yrs.		10 IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Samuel Shaivitz</u>		14 MOTHER'S MAIDEN NAME <u>Stella Kaplan</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>UNKNOWN</u>	
17 INFORMANT <u>Mrs. Blanche Shaivitz, 2108 Northcliff Drive</u>		Address <u>#9</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>2+ yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2+ yrs.</u>	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) <u></u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8) <u></u>	
20c TIME OF INJURY Month, Day, Year hour a.m. <u></u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <u></u> of work <u></u>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f (City or town) (County) (State) <u></u>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CA. EXAMINER <input type="checkbox"/>	
		Address (Street, city, town or county) <u></u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/31/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a REC'D BY REGISTRAR <u>AUG 3 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

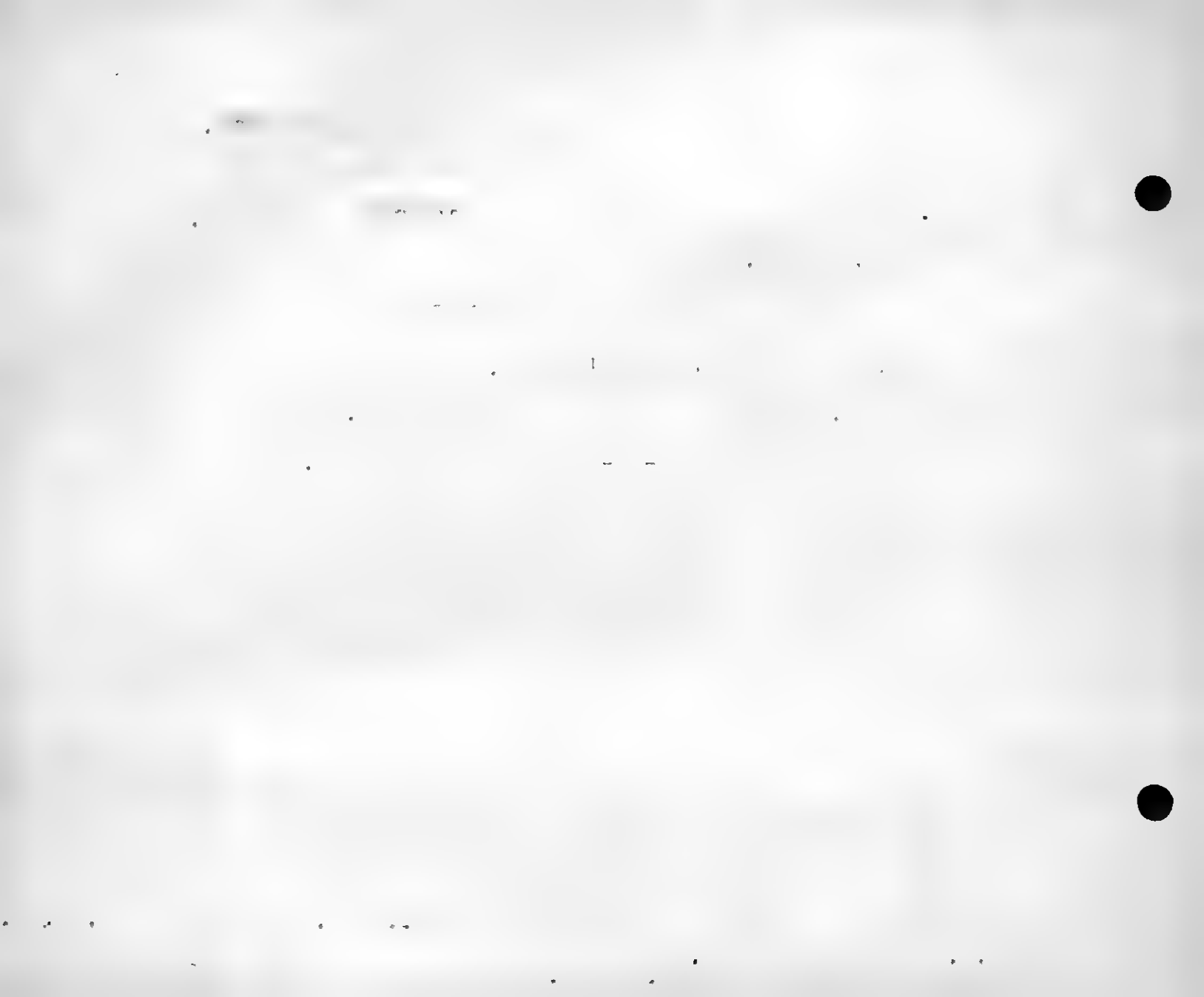
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived 14 or more days before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Dr. Harold J. Shea		4 DATE OF DEATH 7 Month 4 Day Year 67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-26-97
9 AGE (In years last birthday) 70 yrs.		10 UNDER 1 YEAR Months Days Hours Min.	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James W. Shea		14 MOTHER'S MAIDEN NAME Anna A. Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16 SOCIAL SECURITY NO. 212-07-8304A	
17 INFORMANT Mrs. Velma L. Shea		Address (Same)	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Sudden 10+ yrs 10+ yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, room, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 7/4/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Grds. Timonium, Balto. Co. Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.		25a. RECD BY REGISTRAR JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			



09314

CERTIFICATE OF DEATH

09313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. Pages 1 and 2 to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>2 mos 11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp</u>		d. STREET ADDRESS <u>3330 Essex Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Leo N.M.N. Sidlin</u>		4 DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-15-07</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>	9 AGE (In years last birthday) <u>60</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MERCHANT MENDEL SIDLIN</u>		14. MOTHER'S MAIDEN NAME <u>CHANA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>212-26-8822</u>	17 INFORMANT <u>Hospital chart</u> Address <u>?</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Renal disease</u> DUE TO (c) <u>Chronic Pyelonephritis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/28/67</u> , to <u>7/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>A. E. SURONG JR</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. E. SURONG JR</u>		22d. ADDRESS <u>Baltimore County Gen. Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOSES MONTIFIORE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>JUL 12 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles H. Hodge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Item #7 Film G392 8/24/67 hr											
09315											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GARRISON c. LENGTH OF STAY IN 1b 76 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FOXLEIGH NURSING HOME						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 5432 NARCISSIS AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JACOB Middle SYLWERBERG Last SYLWERBERG						4. DATE OF DEATH Month 7 Day 29 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/11/81		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 8 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) POLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME SHOLOM						14. MOTHER'S MAIDEN NAME TOBY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 210-32-2495		17. INFORMANT MR. ALLEN B. SPATZ				Address 10 SOUTH STREET	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) A-fibrillation DUE TO (c) underlying Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Disease Chronic G.C. infection											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) this hospital attended the deceased from 5-24 , 1967, to 7-29 , 1967, that (1) (we) last saw the deceased alive on 7-27 , 1967, and that death occurred at 2:10 PM , from the causes and on the date stated above.											
22a. SIGNATURE David J. Miller						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) David J. Miller						22d. ADDRESS Lisbon Rd. Crofton, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/30/67		23c. NAME OF CEMETERY OR CREMATORY Harmony Park		23d. LOCATION (City, town or county) (State) Baltimore Md			
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc						ADDRESS Garrison Md		25a. REC'D BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE J Charles Juerges	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH
Items 233, 234, 235 Film 6392 8/24/67 kk

CERTIFICATE OF DEATH

09318

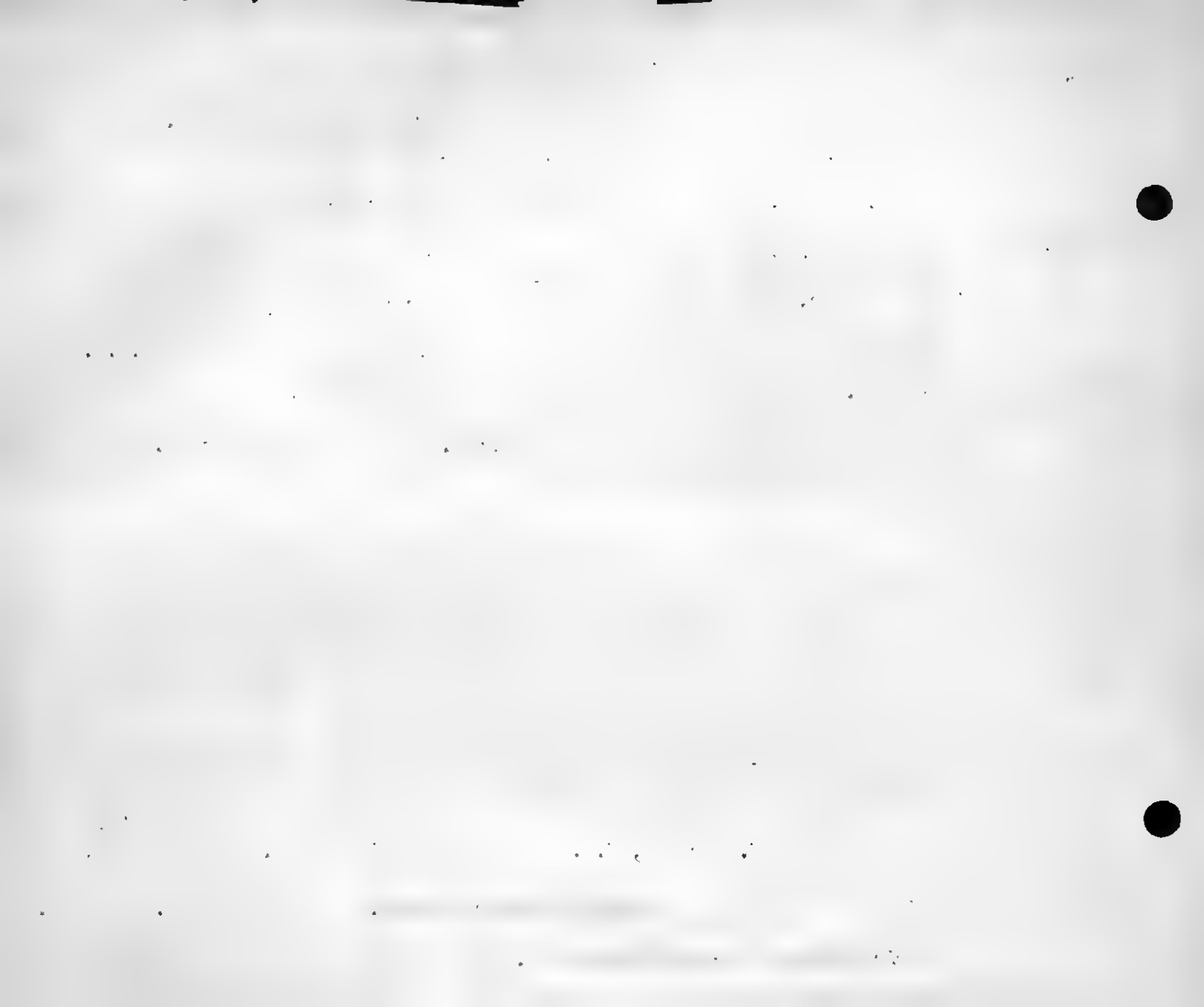
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Alleghany	
c. LENGTH OF STAY IN 1b 17yr11mth18dys		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2 Bedford Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Belle Last Simmons		4. DATE OF DEATH Month July Day 26 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1897
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY factory	
11. BIRTHPLACE (County & State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Albert D. Shields		14. MOTHER'S MAIDEN NAME Elizabeth Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO 215-14-6278	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3:10	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 19 48 to July 26, 19 67 , that (I) (we) last saw the deceased alive on July 26, 19 67 , and that death occurred at 3:10 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE SIGNED 7-26-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-22-67	23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR JUL 28 1967 DATE	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09317 CERTIFICATE OF DEATH 68316									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8609 Dovedale Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 8609 Dovedale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Betty Middle Mae Last Smith					4. DATE OF DEATH Month July Day 16 Year 19 67				
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1950		9. AGE (in years last birthday) 17 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Smith					14. MOTHER'S MAIDEN NAME Edna Thompson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address John P. Smith 8609 Dovedale Rd. Randallstown			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Encephalitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from July 15, 1967 to July 16, 1967 , that (II) (we) last saw the deceased alive on July 15, 1967 , and that death occurred at 3 PM , from the causes and on the date stated above.									
22a. SIGNATURE John J. Darrell								22b. DATE SIGNED 7/17/67	
22c. PHYSICIAN'S NAME (Type) John J. Darrell, M.D.				22d. ADDRESS 9017 Liberty Rd. Randallstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/67		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Meth.			23d. LOCATION (City, town or county) (State) Harford Co. Md.		
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Rd. Balto				25a. REC'D BY REGISTRAR JUL 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09318

09317

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>1737 Joan Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Last First Middle Day Year Month			
3. NAME OF DECEASED (Type or print) <u>Edward J. Smith</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH <u>2/21/83</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Peter Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret PEIS</u> Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>216-16-6811</u>		17. INFORMANT <u>Hospice records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca hung - metastatic</u> 1621 DUE TO (b) <u>Ca lung Prim</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Aspirin</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (This hospital) attended the deceased from <u>11/10/61</u> 19..... to <u>7/31/67</u> 19....., that (I) (we) last saw the deceased alive on <u>7/30/67</u> 19....., and that death occurred at <u>22:05A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert J. Mahon</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M. D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>204 E. Joppa Rd., Towson</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Brooks</u> ADDRESS <u>Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 2 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

CERTIFICATE OF DEATH

09213

09219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN It	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Ctr.			d. STREET ADDRESS 51 Montevideo Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Albert Smith Jr.			4. DATE OF DEATH Month July Day 13 Year 1967		
5. SEX Male	6. COLOR OR RACE Can	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-15		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Delivery Service		11. BIRTHPLACE (County & State, or foreign country) Knoxville, Tenn.	
13. FATHER'S NAME William Albert Smith Sr.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 409-18-4801		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASES FROM CA, LUNG DUE TO (c) RECURRENT CARCINOMA, LUNG			INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SPINAL CORD COMPRESSION; BRONCHOPNEUMONIA					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18) NO			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 7-13-67 , to 7-13-67 that (I) (we) last saw the deceased alive on 7-13-67 , and that death occurred at 1:55 PM , from causes and on the date stated above			
22a. SIGNATURE Wm. V. Gubelchew M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-13-67	
22c. PHYSICIAN'S NAME (Type) Wm. V. Gubelchew		22d. ADDRESS Greater Balto. Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
23d. LOCATION (City or Town) (County) (State) Elkridge, Md.		23e. ADDRESS Singaton Funeral Home		23f. BY REGISTRAR JUL 17 1967	
24. FUNERAL DIRECTOR R.V. Singleton		24b. ADDRESS 6200 Burnside, Md.		24c. SIGNATURE J. J. Judge	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 16 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 912 ST. PAUL STREET	
3. NAME OF DECEASED (Type or print) THEODORE K. SNOVELL		4. DATE OF DEATH Month JULY Day 5 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 4, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		10b. KIND OF BUSINESS OR INDUSTRY FREIGHT	
11. BIRTHPLACE (County & State, or foreign country) HAGERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SNOVELL		14. MOTHER'S MAIDEN NAME ANNIE NICHOLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 41304 216 07 51-34	
17. INFORMANT Theo. K. Snovell-316 Roundhill Rd.-21043		18. CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO (b) 441X DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEURYSM, ARTERIOSCLEROTIC ABDOMINAL AORTA, OLD. PULMONARY EMPHYSEMA, OLD		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc)	20f. (City or town) (County) (State)
21. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from 6/1/67 , 19__, to 7/5/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/5/67 , 19__, and that death occurred at 1:30PM , from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert		22b. DATED SIGNED 7/6/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/7/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME		25a. REC'D BY REG STRAR DATE JUL 7 1967	25b. REG STRAR'S SIGNATURE J. Charles Judge

EDMONDSON AVE. BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09321 CERTIFICATE OF DEATH 09320											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Sheppard & Enoch Pratt Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Purcellville, Va.</u> b. COUNTY <u>Louden</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Purcellville</u> d. STREET ADDRESS <u>Box 247</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G</u> Last <u>Souder</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1881</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Health Officer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Borrowes, Indiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Cloyd Souder</u>						14. MOTHER'S MAIDEN NAME <u>Mary Etta Myers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Army</u>				16. SOCIAL SECURITY NO. <u>224-42-4022</u>		17. INFORMANT Address <u>Wife, Theodate W. Souder, Purcellville, Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome due to senility.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> , 19 <u>67</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>R. B. Finn</u>										22b. DATE SIGNED <u>July 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rolfe B. Finn, M.D.</u>						22d. ADDRESS <u>The Sheppard & Enoch Pratt Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Arlington VA.</u>			
24. FUNERAL DIRECTOR <u>Harry Warr Haight</u> <u>Sylkesville, Md.</u>						25a. REC'D BY REGISTRAR <u>JUL 6 1967</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



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09322

CERTIFICATE OF DEATH

09321

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. LENGTH OF STAY IN TB 28yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt#1 Box 15 Belair Road		e. STREET ADDRESS Rt#1 Box 15 Belair Road	
3. NAME OF DECEASED (Type or print) First Francis Middle Andrew Last Streett		4. DATE OF DEATH Month 7 Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1905
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Machinery Sale	
11. BIRTHPLACE (County & State, or foreign country) Harford Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Andrew Streett		14. MOTHER'S MAIDEN NAME Mary Webster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-1047	
17. INFORMANT Address Kingsville, Md Mrs Helen M. Streett Rt#1 Box 15 Belair Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Cancer of Lung DUE TO (b) Generalized Metastassis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October , 19 65 to July 24 , 19 67 that (I) (we) lost saw the deceased alive on July 23 , 19 67 , and that death occurred at 6A. M, from causes and on the date stated above.			
22a. SIGNATURE S. Edwin Muller M.D.		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) S. Edwin Muller		22d. ADDRESS 1202 St. Paul Street Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-26-1967	23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery	23d. LOCATION (City or Town) (County) (State) Tradshaw, Maryland
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR 36	25b. REGISTRAR'S SIGNATURE J. Charles Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN It Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 5228 Cromarty Road	
3. NAME OF DECEASED (Type or print) Baby First Boy Middle Strong Last		4. DATE OF DEATH Month July Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs 4 IF UNDER 1 YEAR Months Days Hours Min
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Richard B. Strong		14. MOTHER'S MAIDEN NAME Robertson, Dolores, S.,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mother - Dolores Strong - same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 776 X IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-8 , 19 67 , to 7-8 , 19 67 , that (I) (we) last saw the deceased alive on 7-8 , 19 67 , and that death occurred at 4:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Jose A. Aguto		22b. DATE SIGNED 7-8-67	
22c. PHYSICIAN'S NAME (Type) Jose A. Aguto, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-12-67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City or Town) (County) (State) Elkridge, Md.
24. FUNERAL DIRECTOR Charles S. Zeiler		25a. REC'D BY REGISTRAR JUL 13 1967	
25b. REGISTRAR'S SIGNATURE John S. Zeiler			

CERTIFICATE OF DEATH

00323

00324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b XXXXXXXXXX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1209 Camberwell Rd.		d. STREET ADDRESS 1209 Camberwell Rd.	
3 NAME OF DECEASED (Type or print) Helen V. Sullivan		4 DATE OF DEATH Month July Day 17 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-3-1898
9 AGE (In years last birthday) 68 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Sullivan	
14. MOTHER'S MAIDEN NAME Mary Donnelly		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Mr. Edgar Schmanske, 1209 Camberwell Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY 451x IMMEDIATE CAUSE (a) ACUTE DISSEMINATED HEPATITIS DUE TO BRUCCINEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRUCCINEMIA (c) DISEASE			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/11 , 19 67 , to 7/17 , 19 67 , that (I) (we) last saw the deceased alive on 7/17 , 19 67 , and that death occurred at 572 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. John Shaw		22b. DATE SIGNED 7/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. John Shaw		22d. ADDRESS 5800 Edmondson Ave. BALTIMORE, MD.	
23a BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF 7-20-1967	23c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR Jul 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09325

CERTIFICATE OF DEATH

09324

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN TB #21213 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3420 Erdman Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl "A" Sunderland		4. DATE OF DEATH Month July Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1967
9. AGE (In years last birthday) Months 13 Days 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 5612 Gerland Ave, Baltimore Co., Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Maryland		12. CITIZEN OF WHAT COUNTRY? Lawrence Sunderland, grandfather	
13. FATHER'S NAME Lawrence David Sunderland		14. MOTHER'S MAIDEN NAME Laura Jean French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 5612 Gerland Ave, Baltimore Co., Maryland	
17. INFORMANT Lawrence Sunderland, grandfather		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 8, 1967 , to July 8, 1967 , that (I) (we) lost saw the deceased alive on July 8, 1967 , and that death occurred on July 8, 1967 from causes and on the date stated above.			
22a. SIGNATURE Jose A. Aguto, M.D.		22b. DATE SIGNED 7-9-67	
22c. PHYSICIAN'S NAME (Type) Jose A. Aguto, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR JUL 11 1967 DATE	
25b. REGISTRAR'S SIGNATURE John J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09326

CERTIFICATE OF DEATH

09325

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b #21213	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3420 Erdman Avenue	
3. NAME OF DECEASED (Type or print) Baby Girl "B" Sunderland		4. DATE OF DEATH Month July Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1967
9. AGE (In years lost birthday) yrs 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 100. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Maryland		12. CITIZEN OF WHAT COUNTRY? 12	
13. FATHER'S NAME Lawrence David Sunderland		14. MOTHER'S MAIDEN NAME Laura Jean French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 5612 Gerland Ave., 21206	
17. INFORMANT Lawrence Sunderland, grandfather,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 8, 1967 , to July 8, 1967 , that (I) (we) last saw the deceased alive on July 8, 1967 , and that death occurred at 8:30PM , from causes and on the date stated above			
22a. SIGNATURE Jose A. Aguto, M.D.		22b. DATE SIGNED 7-9-67	
22c. PHYSICIAN'S NAME (Type) Jose A. Aguto, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schlimmek Funeral Home, Inc.		25a. REC'D BY REGISTRAR JUL 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

3325

0932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randall's town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. County General</u>		d. STREET ADDRESS <u>7928 Donhill Village</u> Circles RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last <u>Susserman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 1896</u> 9. AGE (in years last birthday) <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OR CONT. BUILDING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Isaac - Susserman</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia</u> ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>216-09-6629-A</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4-10-67 pneumonia</u> DUE TO (b) <u>4-10-67</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4-10-67</u> INTERVAL BETWEEN ONSET AND DEATH <u>4-10-67</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>July 4</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Joseph J. Susserman</u> M.D.		22b. DATE SIGNED <u>7 4 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. SUSSERMAN</u>		22d. ADDRESS <u>Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW HAR SINAI</u>	23d. LOCATION (City or Town) (County) (State) <u>GARRISON, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Baltimore Co.		c. LENGTH OF STAY IN 1b 21212	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home		d. STREET ADDRESS 351 Rodgers Forge Road Register & Sherwood Ave	
3. NAME OF DECEASED (Type or print) First MARY R. Middle BENSON. Last Sutton		4. DATE OF DEATH Month 7 Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. M. Benson		14. MOTHER'S MAIDEN NAME Virginia Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO -----	
17. INFORMANT Mr John R. Sutton, Jr-221 Rodgers Forge Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 44-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO 8+ yrs (c) Arterio Sclerotic Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1967 that (I) (we) last saw the deceased alive on July 14, 1967 and that death occurred at 11:30 AM , from the causes and on the date stated above			
22a. SIGNATURE Charles F. O'Donnell		22b. DATE 7/15/67	
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell		22d. ADDRESS 7501 York Rd. -12	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/67	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION (City, town, or county) (State) Balto. Co.	
24. FUNERAL DIRECTOR'S SIGNATURE Mitchell-Wiedefeld Home, Inc.		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09329

CERTIFICATE OF DEATH

09328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Randallstown			c. LENGTH OF STAY IN 'b 8 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Randallstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3803 Collier Road				d. STREET ADDRESS 3803 Collier Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle W Last Sutton		4. DATE OF DEATH Month July Day 3 Year 1967		9. AGE (In years last birthday) yrs 47		IF UNDER 1 YEAR: Months 3 Days 3 Hours 1 Min. 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 6, 1920		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Benefit Examiner		10b. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (County & State or foreign country) Cordova, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Sutton				14. MOTHER'S MAIDEN NAME Bessie Briddell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes ww 2		16. SOCIAL SECURITY NO. 218-09-6325		17. INFORMANT Mrs. Doris Sutton		3803 Collier Road Randallstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 10/21 , 19 65 , to 7/3 , 19 67 , that (I) (we) lost the deceased alive on 6/28 , 19 67 , and that death occurred at 5 A.M. , from causes on and on the date stated above							
22a. SIGNATURE Ronald Berger		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/3/67			
22c. PHYSICIAN'S NAME (Type) 8501 Liberty Rd. 21207		Balto. Md.		22d. ADDRESS Ronald Berger, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-6-1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Salisbury, Wicomico Co. Md.	
24. FUNERAL DIRECTOR Erving Byers		ADDRESS 8778 Liberty Rd.		25a. REC'D BY REGISTRAR DATE JUL 7 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	



09330

CERTIFICATE OF DEATH

00229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 580 WEST BIDDLE STREET	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE EMANUEL TALLIE		4. DATE OF DEATH Month Day Year JULY 3, 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/97
9. AGE (In years last birthday) yrs 70		10. IF UNDER 1 YEAR Months Days Hours Min 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENTERTAINER		10b. KIND OF BUSINESS OR INDUSTRY SHOW BUSINESS	
11. BIRTHPLACE (County & State, or foreign country) CULPEPPER, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE TALLIE		14. MOTHER'S MAIDEN NAME BELLE PARKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO 294 12 97 99	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLOROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 29, 1967 to JULY 3, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 3, 1967 , and that death occurred at 7:35 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Mustafa H. Adatepe</i>		22b. DATE SIGNED 7/4/67	
22c. PHYSICIAN'S NAME (Type) MUSTAFA H. ADATEPE, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR ADOLPHUS HAISTEAD FUNERAL HOME		25a. REC'D BY REGISTRAR... 1206 W. North Ave. Balto, Md.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE JUL 5 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

09331

09331

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>741 7mo</u>		d. STREET ADDRESS <u>506 Kingston Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bonnie Blink Masonic Homes</u>		8 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Schultz</u> Last <u>TATE</u>		4 DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/22/84</u>
9. AGE (In years last birthday) yrs. <u>83</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12 CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John Schultz</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Wollman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <u>---</u>		17 INFORMANT <u>Md Masonic Home Cockeysville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bilateral Cataract</u> DUE TO (c) <u>Cerebral Sclerosis & Chronic Brain Syndrome</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>July 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 25</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P.M.</u> from causes and on the date stated above.	
22a SIGNATURE <u>J. Hamed</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>		22d ADDRESS <u>MASONIC HOME</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson Inc.</u>		25a. REC'D BY REGISTRAR <u>1050 YORK RD. Towson, Md. 21204</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUL 31 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09332

09331

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>/</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u>		c. LENGTH OF STAY IN life <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>58 St. Joseph Hospital</u>				d. STREET ADDRESS <u>Belfast Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Taylor</u>				4. DATE OF DEATH Month Day Year <u>7 20 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Isiah Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mathilda Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Unifed Taylor Sparks, Ind.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Uremic coma</u> DUE TO <u>Nephrotic syndrome (K-W syndrome)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7/6</u> , 19 <u>67</u> , to <u>7/20</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7/20</u> , 19 <u>67</u> , and that death occurred at <u>5:10 p.m.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Jaime Singzon</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Jaime Singzon, M.D.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pinney Grove</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Ind.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Chaturman Jr.</u>				25a. REC'D BY REGISTRAR <u>1501 Mt. Airy</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

JUL 24 1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09332

09332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b BALTO.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MED CENTER		d. STREET ADDRESS 4905 CROWSON AVE.	
3 NAME OF DECEASED (Type or print) AZULA E. TEAWALT		4 DATE OF DEATH Month 7 Day 7 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-19-79
9 AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State or foreign country) BALTO., MD		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JAMES MC DONNELL		14. MOTHER'S MAIDEN NAME ELIZ. MAC DONALD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 212-05-6708D	
17 INFORMANT DAUGHTER		Address 4905 CROWSON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (a) (this hospital) attended the deceased from JULY 2, 1967 to JULY 7, 1967 that (b) (we) last saw the deceased alive on JULY 7, 1967 , and that death occurred at 12:50 AM , from causes and on the date stated above. 22a. SIGNATURE Keiffer J. Mitchell 22b. DATE SIGNED 7/7/67 22c. PHYSICIAN'S NAME (Type) KEIFFER J. MITCHELL, M.D. 22d. ADDRESS GREATER BALTO. MED. CENTER 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7-11-67 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. 24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. Address 4905 York Rd. Balto., Md. 25a. REC'D BY REGISTRAR DATE JUL 12 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09334

FOR STATE
HEALTH DEPT.

09334

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN It 12 Years		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 8534 Kavanagh Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John N. Trianosky		4. DATE OF DEATH Month July Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/06
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Social Security Administration		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Trianosky		14. MOTHER'S MAIDEN NAME Anna Danko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOC. SEC. NO. 160-03-2416	
17. INFORMANT (Wife) Mrs. Blanche Trianosky, 8534 Kavanagh Rd.		18. ADDRESS Dundalk, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V-Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis EXAMINER'S NAME (Type)		22. DATE SIGNED 7/5/67 6800 Morningside Rd. Dundalk, Md. 21222	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/67	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens Cem.	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. RECEIVED BY REGISTRAR JUL 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death in any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09335

09335

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6119 MT. Ridge Rd				d. STREET ADDRESS 6119 MT. Ridge Rd			
3. NAME OF DECEASED (Type or print) MARY A. TRIMPER				4. DATE OF DEATH Month July Day 5 Year 1967			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1889	
9. AGE (In years last birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State or foreign country) BALTO. Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SPANO				14. MOTHER'S MAIDEN NAME MARY BRADY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-10-6716 D		17. INFORMANT CATHERINE Kirby Address 6119 MT. Ridge Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 1966 to July 5, 1967 , that (I) (we) last saw the deceased alive on July 3, 1967 , and that death occurred at 10:40 A.M. from causes and on the date stated above							
22a. SIGNATURE I. EARL PASS				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7-5-67	
22c. PHYSICIAN'S NAME (Type) I. EARL PASS				22d. ADDRESS 4081 Wilhelmsburg			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City or Town) _____ (County) _____ (State) Md.	
24. FUNERAL DIRECTOR E. S. Mae Nable				ADDRESS 301 Frederick Rd Balto 28 Md.		25a. REC'D BY REGISTRAR JUL 10 1967	
				25b. REGISTRAR'S SIGNATURE James J. Jones			

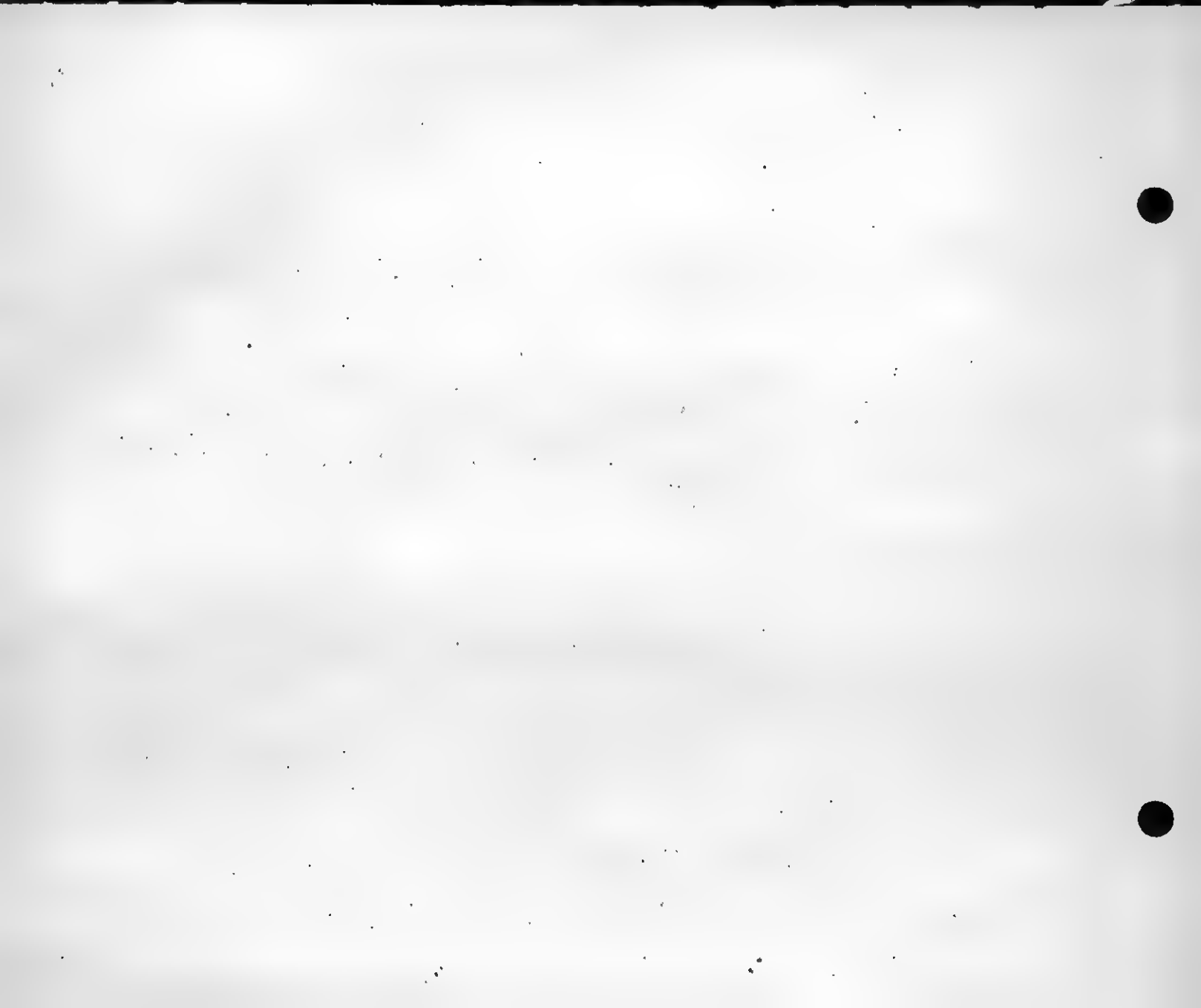
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09336 CERTIFICATE OF DEATH 09333

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton-2111</u>	
c. LENGTH OF STAY IN ID <u>56 yrs.</u>		d. STREET ADDRESS <u>Everett Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Everett Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>M. Jeannette Troyer</u>		4. DATE OF DEATH <u>July 24, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1885</u>
9. AGE (in years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Monkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Kay</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-541203</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. I. C. V. disease</u> 4231 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		18. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage</u>			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> , 19 <u>67</u> to <u>7/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>G. M. France</u> M.D.		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>July 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>
24. FUNERAL DIRECTOR <u>Isaac Kartenslein, New Freedom, Pa.</u>	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09237

09236

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 Old Trail				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 420 Old Trail e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence W. Middle Tuohy Last 4. DATE OF DEATH Month July Day 10 Year 1967				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Nov. 22, 1898 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME John J. Tuohy 14. MOTHER'S MAIDEN NAME Katherine McGaw				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 218-22-0488 17. INFORMANT Mrs. Gertrude Staley Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 10, 1966 , to July 10, 1967 , that (I) (we) last saw the deceased alive on July 10, 1967 , and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Lawrence C. Post				22b. DATE SIGNED 7/10/67			
22c. PHYSICIAN'S NAME (Type) Dr. Lawrence C. Post				22d. ADDRESS 6805 York Rd. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-13-67			
23c. NAME OF CEMETERY OR CREMATORY New Cathedral				23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.				25a. REC'D BY REGISTRAR JUL 13 1967			
25b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

09338

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09337

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor		d. STREET ADDRESS Cecil Apts.	
3. NAME OF DECEASED (Type or print) ELEANOR First Justis Middle Tyler Last TYLER		4. DATE OF DEATH Month July Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7, 1877
9. AGE (In years last birthday) 90 yrs		10. BIRTHPLACE (County & State, or foreign country) Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Tyler		14. MOTHER'S MAIDEN NAME Ida Hamer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-4690	
17. INFORMANT Mr. J. Edward Tyler		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) ASCVD DUE TO (c) Gastrointestinal bleeding		INTERVAL BETWEEN ONSET AND DEATH Days Years Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 9, 1967 to July 2, 1967 , that (II) (we) last saw the deceased alive on June 28, 1967 , and that death occurred at 11 A.M. , from causes and on the date stated above.			
22a. SIGNATURE R K Gundry		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) Dr. Richard Gundry		22d. ADDRESS 2 W. University Pkwy.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-5-67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Pikesville, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home Baltimore, Md. 21212		25a. REC'D BY REGISTRAR JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09339		09339	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN lb 91 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 20 MOBILE COURT	
3. NAME OF DECEASED (Type or print) First Middle Last LACY JOHN TYLER		4. DATE OF DEATH Month Day Year JULY 27, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/28/98
9. AGE (In years last birthday) yrs 69		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (County & State, or foreign country) CHANCE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. TYLER		14. MOTHER'S MAIDEN NAME ELLA JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO 219 14 48 59	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL, ASPIRATION, UNDETERMINED DUE TO ORGANISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO RT. MIDDLE CEREBRAL ARTERY THROMBOSIS (c) 90 DAYS		INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE VASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	
20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from APRIL 27, 1967 to JULY 27, 1967 , that (1) (we) last saw the deceased alive on JULY 27, 1967 , and that death occurred at 7:10 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson</i>		22b. DATE SIGNED 7/28/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31.67	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR ULLAH FUNERAL HOME		25a. REC'D BY REGISTRAR DATE AUG 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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14



CERTIFICATE OF DEATH

00340 00339

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN b. 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. JOSEPH CATH. HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 2038 E. PRATT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) TEOFILA USTASZEWSKA
First Middle Last
4. DATE OF DEATH JULY 2 1967
Month Day Year

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 5-30-1891
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY PCLAND 11. BIRTHPLACE (County & State, or foreign country) USA
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME ? 14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. ? 17. INFORMANT SOPHIE WIEDECK 3547 JUNEWAY
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO ANEMIA
Conditions, if any, which gave rise to immediate cause (b) ?
(a), stating the underlying cause last. DUE TO ?
(c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ?
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐
Hour a.m. p.m. at work at work ?
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ? 20f. (City or town) (County) (State) ?

21. I certify that (I) (this hospital) attended the deceased from 2 July, 1967 to 2 July, 1967, that (I) (we) last saw the deceased alive on 2 July, 1967, and that death occurred at 6:20 PM, from the causes and on the date stated above.

22a. SIGNATURE Ralph E. Updike MD. M.D. 22b. DATE SIGNED 3 July 67
22c. PHYSICIAN'S NAME (Type) Ralph E. Updike MD. 22d. ADDRESS 31 Dogwood Dr. - ELLICOTT CITY, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 7-5-1967 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM. 23d. LOCATION (City, town or county) (State) BALTO. MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc. ADDRESS 4015 CHESTER ST. 25a. REC'D BY REGISTRAR ? 25b. REGISTRAR'S SIGNATURE ?
DATE JUL 3 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

09341

09340

1 PLACE OF DEATH a. COUNTY <u>BALTO Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TURNERS STATION</u>		c. LENGTH OF STAY IN 1b <u>65 yrs</u>	
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION <u>205 BAL/NEW</u>		d. STREET ADDRESS <u>205 Balnew Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Wagstaff</u> Middle <u>Wagstaff</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/1884</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>	
11 BIRTHPLACE (State or foreign country) <u>Roxboro, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>PATTIE Wagstaff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213-079850</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>ACVD</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>7</u> Day <u>8</u> Year <u>1967</u> Hour <u>10</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>present</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/13/67</u> to <u>7/8/67</u> , that I lost sowing the deceased alive on <u>7/8/67</u> and that death occurred at <u>2 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theo C. Patterson</u> M.D. <u>105 Brown Street</u>		DATE SIGNED <u>7-11-67</u>	
PHYSICIAN'S NAME (Type) <u>THEO C. PATTERSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/12/67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		22d. LOCATION (City, town, or county) (State) <u>Arbutus MD</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>MORTON + DyeTT</u> ADDRESS <u>1701 LAURENS</u>		24a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JUL 12 1967</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09341

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9300 Corney Road		d. STREET ADDRESS 9300 Corney Road	
3 NAME OF DECEASED (Type or print) WILLIAM WALLACE		4 DATE OF DEATH Month July Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-21-25
9 AGE (In years last birthday) 41 yrs		10 IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garretaker		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	
11 BIRTHPLACE (State or foreign country) Alabama		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George F. Wallace		14. MOTHER'S MAIDEN NAME Dollie *****	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW2		16. SOCIAL SECURITY NO Family Records	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		22. DATE SIGNED July 7, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/67	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City or Town) (County) (State) Balto Md.	
24 FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford rd.		25a. REC'D BY REGISTRAR DATE JUL 11 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09342

00243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN IS 11 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchill d. STREET ADDRESS R.F.D. #25 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Cynthia Middle Louise Last WALLS		4. DATE OF DEATH Month 7 Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-2-66
9 AGE (In years last birthday) 1 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	10b KIND OF BUSINESS OR INDUSTRY none
11 BIRTHPLACE (County & State, or foreign country) Queen Anne County, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Walls		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFECTED MENINGOMYELOCELE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARNOLD CHIARI MALFORMATION HYDROCEPHALUS CLIP PALATE		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work hot While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/12/66 , 19 67 , to 7/20/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-20-67 , 19 67 , and that death occurred at 1:10 PM , from causes and on the date stated above.			
22a SIGNATURE Placido V. J. Macaraeg, Jr.		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) Placido V. J. Macaraeg, Jr.		22d ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a BURIAL (CREMATION, REMOVAL) (specify) 7-24-67	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY U.S. Md. Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24 FUNERAL DIRECTOR Kewel Funeral Home Phoenix 8-14		25a REC'D BY REGISTRAR AUG 1 1967	25b. REGISTRAR'S SIGNATURE William J. Judge

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09343

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville Pike, Sunnybrook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto, Jarrettsville Pike, Sunnybrook	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jarrettsville Road		d STREET ADDRESS 3701 Milford Avenue	
3. NAME OF DECEASED (Type or print) MARY SHIRLEY WATT		4. DATE OF DEATH Month July Day 7 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-18-1932
9 AGE (In years last birthday) 35 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 7 Months 1 Day 0 Hours 0 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Baltimore	
11 BIRTHPLACE (State or foreign country) Baltimore		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Raymond B. Dorn		14. MOTHER'S MAIDEN NAME Stengel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO William Watt-Oakland Rd. Sykesville, Maryland	
17 INFORMANT Address		18 INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty metamorphosis of liver DUE TO Acute pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty metamorphosis of liver		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED July 7, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22b. ADDRESS (Street, city, town, or county) Baltimore, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7-11-1967	
23c NAME OF CEMETERY OR CREMATORY Balto National Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR 4800 Liberty Hgts. Avenue		25a REC'D BY REGISTRAR JUL 11 1967	
25b REGISTRAR'S SIGNATURE Charles S. Springate		25c REGISTRAR'S NAME Charles S. Springate	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09345

09344

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN It RFD Edgewater, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) First Middle Last Nellie Mae Webb		4. DATE OF DEATH Month Day Year July.29th 19 67	
5 SEX Female	6 CO. OR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-10-94
9 AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (Pract.)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Missouri
12 CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Hartzell	
14. MOTHER'S MAIDEN NAME Maggie Hooper		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-54-3465		17. INFORMANT Records: Spring Grove State Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) ASCVD Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Up sailing 7/18/67			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 11, 19 67 to 7/29, 1967 , that (I) (we) last saw the deceased alive on 7-29 19 67 , and that death occurred at 5:00 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Robert Fisher		22b. DATE SIGNED 7/29/67	
22c. PHYSICIAN'S NAME (Type) Robert Fisher		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, (Type)	23b. DATE THEREOF 7.31.67	23c. NAME OF CEMETERY OR CREMATORY Cremation Lee's	23d. LOCATION (City or Town) (County) (State) Washington D C.
24. FUNERAL DIRECTOR LEE FUNERAL HOME 300 4 ST. N.E.		25a. REC'D BY REGISTRAR DATE AUG 1 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09346

09345

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 7 hrs. 6 min.				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21204 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21204			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 353 Eudowood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		First Weems		Middle Weems		Last Weems	
4. DATE OF DEATH July 21, 1967		Month July		Day 21		Year 19 67	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1967	
9. AGE (In years last birthday) 7		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? None		13. FATHER'S NAME Weems, James Stanley		14. MOTHER'S MAIDEN NAME Whye, Beatrice Marie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT ps. Weems 631 Willow ave. Balto. Md		Address 631 Willow ave. Balto. Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-uterine pneumonia DUE TO (b) Prom. ture rupture of membranes DUE TO (c) Pro. ture rupture of membranes	
19. INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from July 21, 1967 , to July 21, 1967 , that (2) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 9:50 PM , from causes and on the date stated above.		22a. SIGNATURE Lawrence D. Misanik M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22b. DATE SIGNED July 21, 1967		22c. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 7/27/67		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City or town) (County) (State) Balto. Md.		24. FUNERAL DIRECTOR Wm. L. Chatman Jr. 7701 Mt. Ararat St.	
25a. REC'D BY REGISTRAR JUL 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge		25d. REGISTRAR'S ADDRESS Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09347

CERTIFICATE OF DEATH

09346

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 28yrl3dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 2807 Clifton Street	
3. NAME OF DECEASED (Type or print) Margaret Weller		4. DATE OF DEATH July 19, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1900
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR 19 Months 67 Days 19 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Bartholomew Andrew	
14. MOTHER'S MAIDEN NAME Mary Neubart		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Breasts, type undetermined, with generalized metastases. (b) (family refused permission for biopsy.) (c) ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Records: SPRING GROVE STATE HOSPITAL			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18b.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 6, 1967 to July 19, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 19, 1967 , and that death occurred at 7:38 M, from causes and on the date stated above.	
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 7-19-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/21/67	
23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City or town) (County) (State) BALTO MD.	
24. FUNERAL DIRECTOR S.S. 22, 7/21/67		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 301 Trunk Rd Baltimore Md	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

09348

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09347

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Towson		c LENGTH OF STAY IN 1b 13 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last FRANCIS HENRY WELSH		4 DATE OF DEATH Month Day Year July 20, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1928
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing Shipping		10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio	9. AGE (In years last birthday) 39 yrs
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Welsh		14. MOTHER'S MAIDEN NAME Grimes, Mary E.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-20-8171	
17. INFORMANT Patient's History		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from July 7, 1967 , to July 20, 1967 , that I (we) lost saw the deceased alive on July 20, 1967 , and that death occurred at 11:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE John E. Adams		22b. DATE SIGNED 7/20/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22d. ADDRESS Greater Baltimore Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/22/1967	23c. NAME OF CEMETERY Winfield Church Of God	23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz on 241 Sikesville, Md.		25a. REC'D BY REGISTRAR DATE JUL 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		d. STREET ADDRESS 4144 Roland Avenue	
3 NAME OF DECEASED (Type or print) Louise C. Wilhelm		4 DATE OF DEATH Month 7 Day 9 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1885
9. AGE (In years lost birthday) 81 yrs		10. IF UNDER 1 YEAR Months 2 Days 20 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator Ret'd.		10b. KIND OF BUSINESS OR INDUSTRY Mimeo-Graph	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rohleder		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-30-5828	
17. INFORMANT Mr. Charles R. Goldsborough, Jr.		Address Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 1538 IMMEDIATE CAUSE (a) Cancer of Colon DUE TO (b) 20 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 20 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1965 to July 1967 , that (I) (we) last saw the deceased alive on July 1967 , and that death occurred at 2:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE William G. Helfrich		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich		22d. ADDRESS 5006 Roland Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7-12-67	23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR JUL 12 1967	
ADDRESS 4905 York Road Balto., Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Freeland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie R. Williams		4. DATE OF DEATH Month Day Year July 2 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/20
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) York Co. Penna.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Frank Doll		14. MOTHER'S MAIDEN NAME Emma Stokes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-545070	
17. INFORMANT Albert Doll		Address Freeland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema DUE TO Congestive Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Probable myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 7/2/67	
22c. PHYSICIAN'S NAME (Type) M.D.		22d. ADDRESS ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF July 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wiseburg Cemetery		23d. LOCATION (City, town or county) (State) White Hall, Md.	
24. FUNERAL DIRECTOR Jacob Hartenstein		25a. REC'D BY REGISTRAR JUL 7 1967	
25b. REGISTRAR'S SIGNATURE New Freedom, Pa.		25c. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09351

CERTIFICATE OF DEATH

09351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut or Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Harford</u> <u>111 Hickory Ave</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c LENGTH OF STAY IN 1b <u>6 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>333 Harlem Lane Shurgine Wsg. Home</u>		e STREET ADDRESS <u>141 Hickory Ave. Shurgine Wsg. Home</u>	
3 NAME OF DECEASED (Type or print) First <u>(EARL)</u> Middle <u>Carl</u> Last <u>Wimmer</u>		4 DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-13-08</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Aircraft Mechanic</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Va.</u>
13 FATHER'S NAME <u>William Ezra Wimmer</u>		14 MOTHER'S MAIDEN NAME <u>Lois Elizabeth Walton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u> NO		16 SOCIAL SECURITY NO. <u>215-14-8787</u>	17 INFORMANT (with Address) <u>Mrs. ANNA E. Wimmer 141 Hickory Ave. Bel Air Maryland 21014</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Cerebral Vascular Accidents</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 yrs</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic mellitus</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 July</u> , 19 <u>67</u> to <u>13 July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 July</u> , 19 <u>67</u> , and that death occurred at <u>6:45 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>John K. O'Leary</u>		22b. DATE SIGNED <u>13 July 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Cath. Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bradshaw, Balto. Co. Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>	
25b. REGISTRAR'S SIGNATURE <u>John K. O'Leary</u>		DATE <u>JUL 17 1967</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09351

09352

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-13. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY 10 Years		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Edgemere	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6400 Old North Point Road				d. STREET ADDRESS 6400 Old North Point Road	
3 NAME OF DECEASED (Type or print) Edward Thomas Wojcik		4 DATE OF DEATH Month July Day 10 Year 19 67		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9/28/09	9 AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Leary Co. Inc.		11 BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME Edward Wojcik		14. MOTHER'S MAIDEN NAME Susan Strugale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-10-7781		17 INFORMANT Mrs. Theresa Bykowski, 6400 Old North Pt. Rd. Edgemere, Md. 21219	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1 H-S-C-V-DISEASE DUE TO (b) 2 Obesity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Melvin B. Davis		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis		M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				Address (Street, city, town, or county) 6800 Mornington Rd. Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/14/67	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR JUL 13 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND						2 USUAL RESIDENCE (Where deceased lived if inst ill on Residence before admission) a STATE Maryland b COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Company						d. STREET ADDRESS 1125 Steelton Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GEORGE F. WOJCIK			4 DATE OF DEATH Month July Day 27 Year 19 67								
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 20, 1914		9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Maker				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Paul Wojcik						14. MOTHER'S MAIDEN NAME Sophia Giza					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 216-01-7598		17. INFORMANT Paul Wojcik 1125 Steelton Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 830. IMMEDIATE CAUSE (a) <u>Crushing injuries of trunk</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 830. DUE TO (b) <u>Crushing injuries of trunk</u> 830. DUE TO (c) <u>Crushing injuries of trunk</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Walked in front of Fork-lift truck and run over							
20c. TIME OF INJURY Month, Day, Year 7:00 p.m. 7-27 19 67				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) foundry		20f. (City or town) (County) (State) Sparrows Point Balt. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate						22. DATE SIGNED July 28, 1967					
EXAMINER'S NAME (Type) Charles S. Springate, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, town or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-31-1967		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.						25a. RECD BY REGISTRAR JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00354

00353

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE (RURAL)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

HOUSE IN P.O. 16 FUSTING AVE

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)

e. STATE

MD

b. COUNTY

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WHITE HALL

d. STREET ADDRESS

Rt 1 Box 260

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

NAME OF DECEASED
(Type or print)

First WILLIAM

Middle ROY

Last WOODS

4. DATE OF DEATH

Month JULY

Day 18

Year 1967

SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

MAR. 17, 1894

9. AGE (In years last birthday)

73 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

MISC.

11. BIRTHPLACE (County & State, or foreign country)

NEBRASKA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WARREN WOODS

14. MOTHER'S MAIDEN NAME

LUCKY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

56-16-7202 MRS BEATRICE WOODS

17. INFORMANT

Address

WHITE HALL, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Metastatic Ca of Brain

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Primary Ca of Lung

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)

INTERVAL BETWEEN ONSET AND DEATH

6 mos

18 mos

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (Mrs hospital) attended the deceased from 5-20-1967, to 7-18-1967, that (I) (we) saw the deceased alive on 7-17-1967, and that death occurred at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Wilmer K. Gallagher

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

7/18/67

22c. PHYSICIAN'S NAME (Type)

Wilmer K. Gallagher

22d. ADDRESS

6209 Frederick Ave. Balt. 21225 Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

CREMATION 7-17-67

23c. NAME OF CEMETERY OR CREMATORY

GREENMOUNT CEM. BALTIMORE, MD.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John F. Denny, Inc 715 LEE ST.

ADDRESS

25a. REC'D BY REGISTRAR
DATE JUL 20 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

09355

CERTIFICATE OF DEATH

09354

1 PLACE OF DEATH BALTO. Randall's town BALTO. County General Hosp. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY BALTO.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. County General		e STREET ADDRESS 3522 Langrehr Rd. 21207	
3 NAME OF DECEASED (Type or print) First Middle Last Rose NMI Woolfson		4 DATE OF DEATH Month Day Year 7 16 19 67	
5 SEX Female	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 52 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) BALTO. Md. N.Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME GUSTAV JACOBS		14 MOTHER'S MAIDEN NAME Daniel Anna Greenberg	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT Husband		Address Same.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cancer DUE TO (b) Cancer of Liver DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH April 1967 July 1967	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 7-15, 1967, to 7-16, 1967, that (I) (we) last saw the deceased alive on 7-16, 1967, and that death occurred at 2:50 P.M. from causes and on the date stated above.			
22a SIGNATURE Garrison V. Petricio		22b DATE SIGNED 7/14/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF JULY 18, 1967	23c NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	23d LOCATION (City or Town) (County) (State) BALTO MD
24 FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC.		ADDRESS GARRISON MD.	
25a REC'D BY REGISTRAR DATE JUL 18 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

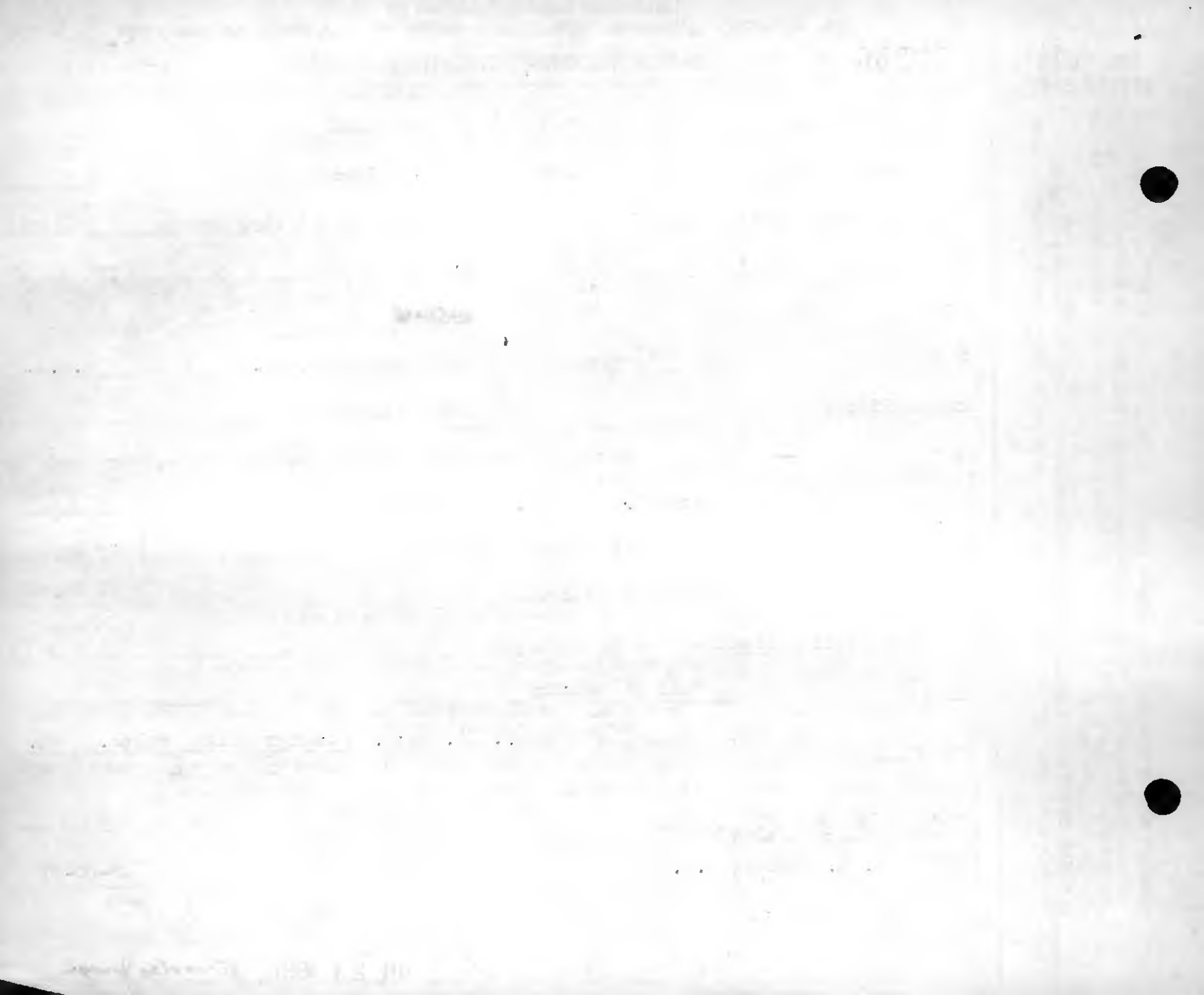
09355

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN Tb 16 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 3327 Forest Park Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Joel Noah ZILBER		4. DATE OF DEATH Month Day Year 7 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-42
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moyshe Zilber		14. MOTHER'S MAIDEN NAME Sarah Palees	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing Orthostatic Pneumonia DUE TO (b) Traumatic Cerebral Damage DUE TO (c) Fracture of Skull		INTERVAL BETWEEN ONSET AND DEATH 8 days 27 days 27 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Institutionalization due to Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in seizure	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6 22 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rswd. St. Hosp.		20f. (City or town) (County) (State) Owings Mills Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples EXAMINER'S NAME (Type) D. D. Caples, M.D.		22. DATE SIGNED 7-20-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 7/21/67	
23c. NAME OF CEMETERY OR CREMATORY Louisa Park		23d. LOCATION (City or Town) (County) (State) Balto, Md.	
24. FUNERAL DIRECTOR Sol Lerner - Broome Road Rd.		25. REC'D BY REGISTRAR DATE JUL 24 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

09357

09356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

1. NAME OF DECEASED (Type or Print) JOSEPH ZWOBAT		2. DATE AND HOUR OF DEATH July 11, 1967	
3. PLACE OF DEATH IN BALTIMORE-MARYLAND BALTIMORE COUNTY FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GARLISON Foxleigh Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 02-1 D. STREET ADDRESS (If rural, give location) 714 Leafydale Terrace	
5. SEX M	6. RACE Caucasian	MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-5-1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10B. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) WISCONSIN
13. FATHER'S NAME Zwobat, Stephen		14. MOTHER'S MAIDEN NAME KOSCZYNSKI, Emma	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 110-01-8084	
17. INFORMANT Joseph W. Zwobat		18. ADDRESS 714 Leafydale Terr 21208 Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4201 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		20. CAUSE OF DEATH (A) Prob. Ac. Myocardial Infarction 1d (B) _____ (C) _____	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT Metastatic Carcinoma prostate, 15 mos.		22. I certify that (I) (this hospital) attended the deceased from 7-9-67 to 7-11-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Daniel Bakal M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.		23D. ADDRESS 3600 LOCHearn DR. Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE July 14, 1967	24C. NAME OF CEMETERY or CREMATORY Balto National	24D. LOCATION (City, town, or county) (State) Fredrick Rd. Balto Md
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967	25B. NAME OF REGISTRAR Charles J. [unclear]	25C. FUNERAL DIRECTOR Loring Myers 8728 Liberty Rd. Randallstown Md. 21139	



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Right side: [Faint text]

Bottom section: [Faint text]

